

Case Number:	CM15-0214574		
Date Assigned:	11/04/2015	Date of Injury:	05/20/1995
Decision Date:	12/15/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	11/01/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New Jersey

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 53 year old female, who sustained an industrial injury on 5-20-1995. The injured worker is being treated for opioid dependence. Treatment to date has included medications management, long term opioid use, acupuncture, outpatient opioid detoxification, psychological evaluation and treatment and home exercise. Per the Follow-up Progress Note dated 9-11-2015, she presented for reevaluation of her chronic pain and pain medication management. She is currently taking MS Contin and Percocet, Neurontin, Lexapro, Wellbutrin, Ambien and Lidoderm patches. Her pain medications decrease her pain by 60% and allow her to remain functional during the day. She is anxious about going into withdrawal, which is a regular event for her, as her medications are not always approved on time. She has been approved for a 5-day Suboxone transition. Objective findings included an antalgic gait and normal posture. The plan of care included refill of medications. Per the Opioid outpatient detox note dated 9-21-2015, the injured worker presented for a 5 day Suboxone transition. Current medications included Ambien, Lexapro, Lidoderm ointment, Neurontin, Suboxone 4mg-1mg sublingual film, Suboxone 8mg-2mg sublingual film and Wellbutrin XL. She was given new prescriptions for Lorazepam and Clonidine. She was discharged on 9-25-2015 and advised to take Suboxone as needed. Authorization was requested for 150 films of Suboxone 4mg-1mg sublingual film. On 10-01-2015, Utilization Review modified the request for 150 films of Suboxone 4mg-1mg sublingual film.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

150 Films of Suboxone 4mg-1mg Sublingual Film: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, long-term assessment, Weaning of Medications. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section Buprenorphine.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that opioids may be considered for moderate to severe chronic pain as a secondary treatment, but require that for continued opioid use, there is to be ongoing review and documentation of pain relief, functional status, appropriate medication use with implementation of a signed opioid contract, drug screening (when appropriate), review of non-opioid means of pain control, using the lowest possible dose, making sure prescriptions are from a single practitioner and pharmacy, and side effects, as well as consultation with pain specialist if after 3 months unsuccessful with opioid use, all in order to improve function as criteria necessary to support the medical necessity of opioids. Long-term use and continuation of opioids requires this comprehensive review with documentation to justify continuation. The MTUS Chronic Pain Treatment Guidelines state that Buprenorphine is primarily recommended for the treatment of opiate addiction, but may be considered as an option for chronic pain treatment, especially after detoxification in patients with a history of opiate addiction. Buprenorphine is recommended over methadone for detoxification as it has a milder withdrawal syndrome compared to methadone. The ODG also states that Buprenorphine specifically is recommended as an option for the treatment of chronic pain or for the treatment of opioid dependence, but should only be prescribed by experienced practitioners. Buprenorphine is only considered first-line for patients with: 1. Hyperalgesia component to pain, 2. Centrally mediated pain, 3. Neuropathic pain, 4. High risk of non-adherence with standard opioid maintenance, and 5. History of detoxification from other high-dose opioids. Weaning opioids should include the following: complete evaluation of treatment, comorbidity, and psychological condition, clear written instructions should be given to the patient and family, refer to pain specialist if tapering is difficult, taper by 20-50% per week of the original dose for patients who are not addicted or 10% every 2-4 weeks with slowing reductions once 1/3 of the initial dose is reached, switching to longer-acting opioids may be more successful, and office visits should occur on a weekly basis with assessments for withdrawal. In the case of this worker, Suboxone was initiated to help the worker safely and effectively wean down on her opioid medications. This has been successful at the 40 mg per day dose and weaning down on Suboxone can progress at the rate of at least 20% per week unless showing difficulty with the wean (pain, withdrawal). The request for 150 films would be more than necessary to follow through with this wean and therefore, would be considered excessive and medically unnecessary. Weaning is still recommended as tolerated. The request is not medically necessary.