

Case Number:	CM15-0216406		
Date Assigned:	11/06/2015	Date of Injury:	09/21/2010
Decision Date:	12/28/2015	UR Denial Date:	10/21/2015
Priority:	Standard	Application Received:	11/03/2015

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: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

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

This is a 57-year-old female with a date of industrial injury 9-21-2010. The medical records indicated the injured worker (IW) was treated for cervical disc herniation with left upper extremity radicular symptoms; status post left shoulder arthroscopy (2012); and status post left carpal tunnel release and left lateral and medial epicondylitis surgery (2011). In the progress notes (9-9-15 and 10-7-15), the IW reported her neck pain and upper extremity radicular symptoms were 4 out of 10 since her epidural steroid injections on 8-13-15; this was a 50% decrease in pain. She also reported less numbness in her hands and improved ability to perform activities of daily living. She had carpal tunnel symptoms in the right hand, including numbness and tingling, and left shoulder pain. Medications included Prilosec, Remeron, Voltaren gel, Anaprox, Doral and Imitrex; Norco was to be discontinued and Butrans patch was prescribed. On examination (10-17-15 notes), she was in mild to moderate distress. There was posterior cervical spine tenderness bilaterally and increased muscle rigidity with numerous trigger points. Range of motion was decreased and there was muscle guarding. Treatments included cervical epidural steroid injections, left shoulder steroid injections, physical therapy, acupuncture, home exercise program and medications. Neurontin caused lethargy. A Request for Authorization was received for Butrans patch 10mcg per hour, #4 patches. The Utilization Review on 10-21-15 non-certified the request for Butrans patch 10mcg per hour, #4 patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Butrans Dis 10mcg/hr quantity 4 patches: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Buprenorphine, Opioids (Classification).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Buprenorphine, Opioids, criteria for use.

Decision rationale: With regard to Buprenorphine, the MTUS CPMTG states: "recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction (see below for specific recommendations). A schedule-III controlled substance, buprenorphine is a partial agonist at the mu-receptor (the classic morphine receptor) and an antagonist at the kappa-receptor (the receptor that is thought to produce alterations in the perception of pain, including emotional response). In recent years, buprenorphine has been introduced in most European countries as a transdermal formulation ("patch") for the treatment of chronic pain. Proposed advantages in terms of pain control include the following: (1) No analgesic ceiling; (2) A good safety profile (especially in regard to respiratory depression); (3) Decreased abuse potential; (4) Ability to suppress opioid withdrawal; & (5) An apparent antihyperalgesic effect (partially due to the effect at the kappa-receptor)." Per progress report dated 6/23/15 it was noted that the injured worker continued to work 48 hours per week with no restrictions despite ongoing pain. She discontinued norco as it caused GI symptoms including feeling nauseated. She also relies on Anaprox DS 550 mg which she feels has enable her to discontinue taking norco. It was noted that she was also unable to tolerate Ultram as it causes her to feel irritable. I respectfully disagree with the UR physician's assertion that Butrans is not supported as it is not a first-line medication. The injured worker has failed 2 first line medications, norco and tramadol. The request is medically necessary.