MAXIMUS Federal Services

Case Number:	CM15-0041567		
Date Assigned:	03/11/2015	Date of Injury:	05/28/1999
Decision Date:	04/14/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	03/04/2015

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: District of Columbia, Virginia
Certification(s)/Specialty: Internal Medicine

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 57-year-old female, who sustained an industrial injury on May 28, 1999. The injured worker had reported neck and low back pain. The diagnoses have included failed back surgery syndrome, lumbar radiculopathy and chronic pain. Treatment to date has included medications, radiological studies, physical therapy, Toradol injection, a spinal cord stimulator implantation, left knee pain and a lumbar fusion. Current documentation dated January 27, 2015 notes that the injured worker complained of neck pain with radiation to the bilateral upper extremities. She also reported low back pain with radiation to the bilateral lower extremities. The injured worker noted that her pain was worsening. Physical examination of the lumbar spine revealed tenderness to palpation, spasms and myofascial trigger points in the paraspinal muscles bilaterally. The range of motion was severely limited secondary to pain. A straight leg raise test was positive bilaterally. The treating physician's recommended plan of care included Naloxone HCL 0.4 mg/0.4 ml prefilled syringe times two, one kit for opioid overdose.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naloxone 0.4mg/0.4ml 1mL prefilled syringe times 2 one kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 27.

Decision rationale: Per MTUS: Available formulations: Buprenorphine hydrochloride: Buprenex: Supplied as an injection solution; Subutex: Supplied as a sublingual tablet in 2 daily dosage strengths (2 mg or 8 mg). Buprenorphine hydrochloride and naloxone hydrochloride: Suboxone: Also supplied as asublingual tablet in 2 dosage strengths (2/0.5 mg or 8/2 mg). Developed to have a lower intravenous (IV) misuse potential. When injected IV, naloxone is intended to cause withdrawal effects in individuals who are opiate-dependent, and to prevent the "high-effect" related to opioids such as euphoria. Pharmacokinetics: After sublingual administration the onset of effect occurs in 30 to 60 minutes. Peak blood levels are found at 90 to 100 minutes, followed by a rapid decline until 6 hours, and then a gradual decline over more than 24 hours. (Helm, 2008)(Koppert, 2005) Indications: Treatment of opiate agonist dependence, (FDA Approved indication includes sublingual Subutex and Suboxone): Recommended. When used for treatment of opiate dependence, clinicians must be in compliance with the Drug Addiction Treatment Act of 2000. (SAMHSA, 2008) Buprenorphine's pharmacological and safety profile makes it an attractive treatment for patients addicted to opioids. Buprenorphine's usefulness stems from its unique pharmacological and safety profile, which encourages treatment adherence and reduces the possibilities for both abuse and overdose. Studies have shown that buprenorphine is more effective than placebo and is equally as effective as moderate doses of methadone in opioid maintenance therapy. Few studies have been reported on the efficacy of buprenorphine for completely withdrawing patients from opioids. In general, the results of studies of medically assisted withdrawal using opioids (e.g., methadone) have shown poor outcomes. Buprenorphine, however, is known to cause a milder withdrawal syndrome compared to methadone and for this reason may be the better choice if opioid withdrawal therapy is elected. (McNicholas, 2004) (Helm, 2008) Per review of the clinical data provided, the patient did not appear to have issues with opiate addiction and this medication would not be indicated.