

<b>Case Number:</b>	CM15-0052193		
<b>Date Assigned:</b>	04/15/2015	<b>Date of Injury:</b>	03/17/2008
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	03/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 53 year old male, who sustained an industrial injury on 3/17/08. The injured worker was diagnosed as having spinal stenosis of lumbar region, pain in thoracic spine, lumbar disc degeneration, thoracic disc disorder with myelopathy, neuralgia, neuritis and radiculitis, fasciitis, painful respiration, long term use of medications and lumbago. Treatment to date has included oral medications including opioids, transdermal narcotics, physical therapy and home exercise program. Currently, the injured worker complains of low back and bilateral lower extremity pain. His current medications provide him with a significant degree of pain relief and improved function. Physical exam noted he ambulated with a walker. The treatment plan consisted of prescriptions of Suboxone, amitriptyline and Dilaudid.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Suboxone MIS 4-1mg 15 day supply #45:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Buprenorphine for chronic pain and Buprenorphine for opioid dependence.

**Decision rationale:** The MTUS notes that on-going management actions should include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drugtaking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The ODG guidelines note that Suboxone (Buprenorphine hydrochloride and naloxone hydrochloride sublingual film) is recommended as an option for treatment of chronic pain (consensus based) in selected patients (not first-line for all patients). Suggested populations: (1) Patients with a hyperalgesic component to pain; (2) Patients with centrally mediated pain; (3) Patients with neuropathic pain; (4) Patients at high-risk of non-adherence with standard opioid maintenance; (5) For analgesia in patients who have previously been detoxified from other high-dose opioids. Use for pain with formulations other than Butrans is off-label. Due to complexity of induction and treatment the drug should be reserved for use by clinicians with experience. Drug description: Buprenorphine is a schedule-III controlled substance. Its mechanism of action is complex, involving four different opioid receptors at central and peripheral sites. It is primarily classified as a partial mu-agonist and kappa antagonist. It blocks effects of subsequently administered opioid agonists. Buprenorphine hydrochloride and naloxone hydrochloride sublingual film (Suboxone; no generics): Available as a film in doses of buprenorphine/naloxone of 2mg/0.5mg, 4mg/1 mg, 8mg/2 mg and 12mg/3 mg. Tablet formulations are available as 2mg/0.5mg and 8mg/2mgs. Discontinuation of branded Suboxone sublingual tablets is to occur on 3/18/13, being replaced by the sublingual film described above. The medical records document increased levels of function including increased ability to walk. No significant side effects are reported. There are no aberrant drug behaviors and urine drug testing results have been appropriate. Fentanyl patches and morphine did not provide significant benefit. Dilaudid has been helpful but a trial of methadone as an alternative was not successful. The injured worker is

not a surgical candidate due to liver failure. The treating physician, who is a pain specialist, has recommended a 2 week trial of Suboxone as the only additional option available for pain control. This trial, as ordered by the treating physician is a reasonable alternative and is considered to be medically necessary.