MAXIMUS Federal Services

Case Number:	CM14-0181967		
Date Assigned:	11/06/2014	Date of Injury:	07/13/2011
Decision Date:	12/09/2014	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/03/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 65-year old male with a date of injury of 07/13/2011. He had a slip and fall injury. On 09/06/2011 he had a lumbar MRI that revealed degenerative changes with neural foraminal stenosis. On 01/13/2012 Electrodiagnostic studies were negative. On 04/25/2014 an EMG/NCS revealed a chronic right L5 radiculopathy. On 09/17/2014 he had low back pain radiating down both legs. Gait was normal. He has been treated with physical therapy, epidural steroid injections, medications, pool therapy, chiropractic therapy, back brace and a functional restoration program. Tramadol was discontinued because of a dry mouth. On 10/15/2014 he had 7/10 low back and right hip pain. Right hip x-ray on 09/18/2014 was negative. Gait was normal. He had right hip tenderness to palpation with a decreased range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 Troches of Buprenorphine 0.1mg Sublingual: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Bprenorphine Page(s): 26-27.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines (Effective July 18, 2009) Page 26 and 27. Buprenorphine Recommended for treatment of opiate addiction. Also 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. Proposedadvantages 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. 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 a sublingual tablet in 2 dosage strengths (2/0.5 mg or 8/2 mg). Developed to have a lower intravenous (IV) misuse potential. Indications: Treatment of opiate agonist dependence (FDA Approved indication includes sublingualSubutex and Suboxone: Recommended. When used for treatment of opiate dependence, clinicians must be in compliance with the Drug Addiction Treatment Act of 2000. 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 andis 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. There is no documentation of opiate abuse, opiate detoxification or opiate antagonist dependence.