

Case Number:	CM14-0216947		
Date Assigned:	01/06/2015	Date of Injury:	06/30/2006
Decision Date:	03/05/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/28/2014

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. 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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:

The worker is a 52-year-old male with an original date of injury of June 30, 2006. The covered body regions include the cervical spine and lumbar spine. The patient has been treated with physical therapy, activity restriction, epidural steroid injections, and pain medications. That patient underwent detoxification in 2012 and was placed on Suboxone. The disputed issues include the request for Suboxone, a proton pump inhibitor, and Lidoderm patches. A utilization review determination has noncertified these requests. The rationale for the non-certification of the Suboxone was that there was no objective evidence of significant improvement in pain or function. Regarding the proton pump inhibitor, the patient is reported to have a history of Gerd and gastritis associated with oral medications. The reviewer felt that there is no indication that the patient has been trialed on omeprazole which is considered a first-line proton pump inhibitor. With regard to the request for Lidoderm, the medical records did not establish that the patient had failed the trial of first-line therapy, and the cervical and lumbar radiculopathy do not represent a localized peripheral source of neuropathic pain."

IMR ISSUES, DECISIONS AND RATIONALES

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

Suboxone 8/2mg #60, prescribed 11/24/14: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC, Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 26-27.

Decision rationale: The Chronic Pain Medical Treatment Guidelines 8 C.C.R.9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 26-27 state the following regarding 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. 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). (Kress, 2008) (Heit, 2008) (Johnson, 2005) (Landau, 2007) 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. 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). Regarding the request for buprenorphine, California Pain Medical Treatment Guidelines state that buprenorphine is recommended for treatment of opiate addiction/dependence. Within the documentation available for review, there is documentation of opiate dependence and the patient has undergone previous detoxification. There is monitoring for

aberrant behaviors as evidenced by a urine drug screen on June 18, 2014. The primary indication of Suboxone in this case is for opioid dependence, and therefore there does not need to be documentation of functional improvement on this medication. However, there should be further history obtained regarding the patient's cravings, side effects, in other history of compliant behavior. These factors are important in monitoring opioid dependence treatment, although they are not explicitly specified in the MTUS. Overall, the use of Suboxone is appropriate in this patient per guidelines and is medically necessary.

Prevacid 30mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines , Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors Page(s): 68-69.

Decision rationale: The Chronic Pain Medical Treatment Guidelines on page 68-69 states the following regarding the usage of proton pump inhibitors (PPI): Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). In the case of this injured worker, there is documentation of GERD. Therefore the use of a proton pump inhibitor is appropriate. It should be noted that the utilization reviewer's commentary that certain proton pump inhibitors are considered first-line does not take precedence over the MTUS (which is the guideline of first priority), which have no specification regarding which particular proton pump inhibitor should be utilized first. This request is medically necessary.

Lidoderm patch 5% #90 prescribed 11/24/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Regarding request for topical Lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the first line therapy such as tricyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no documentation of localized peripheral pain as recommended by guidelines. Although cervical and lumbar radiculopathy are neuropathic pain states, they are not localized peripheral pain states that are similar to etiology as the FDA indications provided terms such as postherpetic neuralgia. As such, the currently requested Lidoderm is not medically necessary.