

<b>Case Number:</b>	CM15-0018903		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	08/01/1994
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 female who sustained an industrial injury on 8/1/94. The injured worker reported symptoms in the neck and shoulder. The diagnoses included right shoulder impingement syndrome status post arthroscopic debridement, chronic cervical spinal pain, right upper extremity thoracic outlet syndrome. Treatments to date include subacromial injections, occipital nerve rot blocks, and oral pain medications. In a progress note dated 1/15/15 the treating provider reports the injured worker was with neck and shoulder pain and "experiencing aching and decreased range of motion, numbness and tingling in the right and left arm and radicular pain in right and left arm." On 1/29/14 Utilization Review non-certified the request for Prospective use of Butrans patch 5 micrograms #4 x 2 refills. The MTUS, ACOEM Guidelines, (or ODG) was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prospective use of Butrans patch 5mcg #4 times 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine HCL, pages 26-27.

**Decision rationale:** Submitted reports have not demonstrated the indication or medical necessity for this medication request. Per MTUS Chronic Pain, BuTrans or Buprenorphine is a scheduled III controlled substance recommended for treatment of opiate addiction or opiate agonist dependence. Request has been reviewed previously and non-certified for rationale of lack of pain contract, indication, and documentation of opioid addiction. Buprenorphine has one of the most high profile side effects of a scheduled III medication. Per the Guidelines, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial and use should be reserved for those with improved attributable functional outcomes. This is not apparent here as this patient reports no change in pain relief, no functional improvement in daily activities, and has not decreased in medical utilization or self-independence continuing to treat for chronic pain symptoms. There is also no notation of any functional improvement while on the patch nor is there any recent urine drug screening results in accordance to pain contract needed in this case. Without sufficient monitoring of narcotic safety, efficacy, and compliance for this individual along with no weaning process attempted for this chronic injury. Medical necessity for continued treatment has not been established for Buprenorphine. The Prospective use of Butrans patch 5mcg #4 times 2 refills is not medically necessary and appropriate.