

Case Number:	CM15-0178398		
Date Assigned:	09/18/2015	Date of Injury:	01/20/2010
Decision Date:	10/22/2015	UR Denial Date:	08/22/2015
Priority:	Standard	Application Received:	09/10/2015

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: Massachusetts

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 injured worker is a 33 year old male, who sustained an industrial-work injury on 1-20-10. He reported initial complaints of multiple areas of pain due to gunshot wounds. The injured worker was diagnosed as having gunshot wound of abdomen, left leg fracture, bilateral lower extremity weakness, neuropathy, chronic pain syndrome, depression, anxiety. Treatment to date has included medication, surgery (complete hardware removal left tibia, laparoscopic lysis of adhesions, left lumbar sympathetic block, left tarsal tunnel release, neuroplasty-decompression of the left mid-tibial nerve, medial plantar nerve, and lateral plantar nerve and calcaneal nerve, re-do tarsal tunnel release). Currently, the injured worker complains of pain in posterior neck, bilaterally, and upper back, low back down the buttocks and into his bilateral legs, and gastric complaints. Pain is reported to be 6-10 out of 10. Prolonged walking aggravates the pain and rest, medications, and physical therapy makes it better. Per the primary physician's progress report (PR-2) on 8-5-15, preference was to decrease medication but he experienced withdrawal symptoms to include increased pain and dizziness. Exam noted soft but bloated abdomen, tenderness over lumbar spine, unable to extend due to pain, exquisitely tender left calf, ankle, and foot, multiple healed surgical scars, right foot drop, DTR (deep tendon reflexes) are 2+ at patella and Achilles, right unable to elicit. Current plan of care includes medication adjustment. The Request for Authorization requested service to include Buprenorphine 2mg sublingual qty: 60.00. The Utilization Review on 8-22-15 denied the request due to lack of CURES report, drug testing pain contract, or comparison VAS scores for effectiveness, per the CA MTUS (California Medical Treatment Utilization Schedule) Chronic Pain treatment Guidelines 2009.

IMR ISSUES, DECISIONS AND RATIONALES

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

Buprenorphine 2mg sublingual qty: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Buprenorphine, Weaning of Medications.

Decision rationale: The claimant sustained a work injury in January 2010 and is being treated for chronic pain as the result of a gunshot injury with left lower extremity injuries and including a diagnosis of CRPS. When seen, there was lumbar tenderness and he was unable to extend the spine due to pain. There was left ankle, foot, and calf tenderness. There was a right footdrop. He had been decreasing Percocet and wanted to discontinue it due to poor tolerance and insomnia but was having symptoms of withdrawal with increased pain and dizziness. His Percocet was discontinued and Subutex was prescribed. Other medications include Opana ER. Guidelines address the weaning of opioid medication. A slow taper is recommended and the longer the patient has taken opioids, the more difficult they are to taper. A suggested taper is 10% every 2 to 4 weeks. In this case, the claimant has not failed an appropriate weaning of Percocet. He is continuing to take extended release hydromorphone and prescribing Subutex would be expected to also block the effect of this medication, which is not what is intended. The request is not appropriate or medically necessary.