

Case Number:	CM15-0061335		
Date Assigned:	04/07/2015	Date of Injury:	11/12/2000
Decision Date:	05/12/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	03/31/2015

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: Colorado

Certification(s)/Specialty: Family Practice

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 64-year-old male who sustained a work related injury November 12, 2000. Past history included ankylosing spondylitis, hypertension, and nasal MRSA infection. According to a treating physician's progress notes, dated March 24, 2015, the injured worker presented for re-evaluation, with no change in condition. He has complaints of continued chronic low back pain with radicular symptoms to his bilateral lower extremities. His tolerance for walking or standing is limited to 30 minutes with the use of pain medication and he notes a 60% reduction of pain with the use of medication, rated 4-5/10. Assessment is documented as chronic low back pain; lumbar degenerative disc disease; bilateral sciatic pain with insomnia and depression. Treatment plan included continued use of TENS unit, repeat urine drug screen, and continued medication regimen with Suboxone 8/2mg sublingual strips taken sublingually every day. The physician provided two refills of his medication and will follow-up with patient in two months.

IMR ISSUES, DECISIONS AND RATIONALES

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

Suboxone sublingual film 8 mg - 2 mg, sixty count with one refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 26-27, 75,79-80, 85, 88, 94-95.

Decision rationale: Per the Guidelines, Suboxone (Buprenorphine) is a recommended treatment for opioid addiction as well as a treatment option for chronic pain relief. Suboxone is classified as a partial agonist-antagonist opioid that has less potential for abuse than pure agonist opioids. (Side effects include hallucinations and dysphoria.) It can be particularly useful in patients with a history of detoxification from opioid addiction. Suboxone is FDA approved for treatment of opiate agonist dependence: Prescribers must be in compliance with the Drug Addiction Treatment Act of 2000. (SAMHSA, 2008) Suboxone has a specific pharmacological design that limits likelihood of overdose or abuse. While few studies support the use of Suboxone, or other medications to completely wean from opioids, Suboxone is known to have milder withdrawal syndrome, so is the best choice for opiate addiction treatment. However, Suboxone is an opioid, and needs to be managed as such. The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. (Address diversion or procuring prescriptions from more than one provider.) Do not decrease dose if effective. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids and aggressive or threatening behavior in clinic. Per the Guidelines. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence" (including urine drug testing negative for prescribed substances on 2 occasions). 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work. Has patient had improved function and decreased pain with the opioids. For those at high risk of opioid abuse, the following are recommended to prevent misuse/addiction. a) Opioid therapy contracts. See Guidelines for Pain Treatment Agreement. b) Limitation of prescribing and filling of prescriptions to one pharmacy. c) Frequent random urine toxicology screens. d) Frequent evaluation of clinical history, including questions about cravings for the former drug of abuse (a potential early sign of relapse). e) Frequent review of medications (including electronic medical record evaluation when. f) Communication with pharmacists. g) Communication with previous providers and other current providers, with evidence of obtaining medical records. (It has been recommended that opioids should not be prescribed on a first visit until this step has been undertaken.) h) Evidence of participation in a recovery program (12-step or follow-up with a substance abuse counselor), such as speaking to his/her sponsor for the 12-

step program. i) Establishment of goals of treatment that can be realistically achieved. j) Initiation of appropriate non-opioid adjunct medications and exercise programs. k) Utilize careful documentation, and in particular, that which is recommended in the State in which opioids are prescribed. l) Incorporate family and friends for support and education. For the patient of concern, the records do indicate that patient's pain and function are improved with current regimen which includes Suboxone and TENS unit. (There is an objective measure of function mentioned though no clinical tool is used to verify functional improvement) There is no documentation that patient continues with physical therapy or home exercise program, and incomplete documentation of adjunct medications patient has tried and failed. Discussion of medication side effects and use of urine drug screens are documented. However, in this patient with a history of polysubstance abuse and failed detoxification attempt, there is no documentation of discussion / monitoring for aberrant drug taking behavior, except urine drug screens. There is no documentation that controlled substance database is being checked or that other providers are being consulted. This patient is at high risk for opioid abuse and there is little evidence that he is being monitored for aberrant behaviors, other than urine drug screens. Without additional monitoring, as per the Guidelines, the Suboxone is not medically indicated.