

Case Number:	CM15-0094016		
Date Assigned:	05/20/2015	Date of Injury:	11/24/1999
Decision Date:	06/24/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	05/15/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 61 year old male, who sustained an industrial injury on 11/24/1999. The injured worker was noted to have a "pop" in his back that caused immediate back pain and loss of feeling in his legs. On provider visit dated 04/10/2015 the injured worker has reported chronic back pain, described as constant, aching, sharp, shooting and stabbing. On examination he was noted to have 10/10 on pain scaled when the pain is at its worse and average pain was noted as 8/10. And pain was noted to be worse on movement. The diagnoses have included chronic low back pain status post four surgeries with L2 to S1 fusion, failed back surgery syndrome and right lumbar radiculopathy. Treatment to date has included surgical intervention, pain management consultation, injections and medication which included Suboxone and was noted as should be a candidate to continue Suboxone for maintenance. No clear evidence of any significant reduction in pain level or improvement in functional capacity resulting from its use was noted. The provider requested Suboxone MIS 8-2 mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Suboxone MIS 8-2 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Opioids Page(s): 78.

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

Decision rationale: According to MTUS guidelines, Suboxone is recommended to treat opiate addiction. In this case, there is no evidence provided that the need for Suboxone 9 and even the increase in dose made any difference. There is no evidence of return to work or significant functional improvement. Therefore, the prescription of Suboxone MIS 8-2 mg #90 is not medically necessary.