MAXIMUS Federal Services

Case Number:	CM13-0031656		
Date Assigned:	01/10/2014	Date of Injury:	07/03/2012
Decision Date:	02/04/2014	UR Denial Date:	09/23/2013
Priority:	Standard	Application Received:	10/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. 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 physician 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/services.

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 claimant is a 46-year-old English-speaking female. Her job duties involved driving to field appointments, doing case management of 30+ adult clients, conducting field trips, facilitating various groups for counseling and cooking, driving clients to various appointments, setting up for all-year-around holidays/ decorations, doing paperwork, attending meetings, and going grocery shopping. She utilized various office machines, and worked with tables, chairs, kitchen appliances, and pots/pans. She frequently walked, stood, sat, bent the waist, reached, climbed stairs/ladders, and lifted 1-50 pounds. On occasion, she knelt, squatted, pushed, pulled, walked on uneven ground, gripped, grasped, twisted the wrist and hands, jumped/ran, and lifted 51-75 pounds. The patient worked eight hours per day, five days per week. The patient underwent a pre-employment drug screen. The patient denies having any concurrent employment. In 2011, the patient presented to her private physician, [redacted], and later to [redacted], or [redacted], due to persistent GI symptoms. She was provided with medication, and referred to a GI specialist, [redacted] to ongoing GI symptoms, the patient was admitted into the hospital on several occasions, and underwent laboratory work, CT scans, and sonograms. On July 3, 2012, the patient was driving to a County meeting, when she rear ended the vehicle in front of her, causing injury to her neck and left shoulder, as well as to the right thigh, from severe pressure to the brake pedal. At the time of the accident, the patient was wearing her seat restraints. She reported the motor vehicle accident and injury to her employer, after which time, she went to the County meeting, with worsening of her orthopedic symptoms. She then presented to [redacted], where she was examined, x-rayed, and prescribed medication, which caused increased stomach pain and diarrhea, in addition to nausea. On July 4, 2012, the

IMR ISSUES, DECISIONS AND RATIONALES

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

4 Butrans patches (10 mg): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Agonist Section 127.

Decision rationale: CA-MTUS (Effective July 18 2009) section of Butrans (buprenorphine) is 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 [redacted] ([redacted] package insert : Butrans is indicated for the management of moderate to severe chronic pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time. 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) Limitations of Use : Butrans is not for use: -As an as-needed (prn) analgesic -For pain that is mild or not expected to persist for an extended period of time -For acute pain -For postoperative pain unless the patient is already receiving chronic opioid therapy prior to surgery or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time Based on the medical records reviewed, the request for Butrans patches 4mg (10mg) is not medically necessary since the patient pain level decreased from 1-8/10 to 1-7/10, while on this medication. Medical records from [redacted] dated 09/11/2013 stated "Since last visit patient went to ER September 8, 2013 [redacted] secondary to abdominal pain, back spasms, nausea and vomiting. States butrans was not authorized prescription on September 6, 2013, treated with fentanyl patch and Vicodin 7.5/500 mg/15 ml paid out of pocket. The claimant presently complains of low back pain that radiates to the left lower extremity. The patient also complains of neck pain that radiates to bilateral upper extremities. The patient's pain level is increased with average pain level of 7/10 with medications and 8/10 without medication. Also according to [redacted] medical report, the butrans patch was not authorized, and fentanyl was substituted instead. Therefore the request for Decision for 4 Butrans patches (10 mg) is not medically necessary.

. 5 fentanyl patches (25 mg): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Agonist Section 127.

Decision rationale: CA-MTUS (Effective July 18 2009), page 44 and 47 states that DuragesicÂ® (fentanyl transdermal system) is not recommended as a first-line therapy. Duragesic is the trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin. It is manufactured by [redacted] and marketed by [redacted] (both subsidiaries of [redacted]). The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. Fentanyl is an opioid analgesic with a potency eighty times that of morphine. Weaker opioids are less likely to produce adverse effects than stronger opioids such as fentanyl. This patient continues to be in pain despite various pain management regimen. A short course of long acting opioid such as 5 FENTANYL PATCHES (25 MG) is medically necessary.

100 tablets of hydrocodone-acetaminophen (7.5 mg/500 mg): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Agonist Section 127.

Decision rationale: CA-MTUS (July 18, 2009) Chronic Pain Medical Treatment Guidelines Norco (hydrocodone (is a semi-synthetic opioid which is considered the most potent oral opioid) and Acetamenophen) is Indicated for moderate to moderately severe pain however, page 76 through 77 MTUS stipulated specific criteria to follow before a trial of opioids for chronic pain management. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics that may be used to manage chronic pain. These medications are generally classified according to potency and duration of dosage duration. Evidence-based guidelines recommend the use of opioid pain medications for the short-term treatment of moderate to severe pain. Ongoing use of opiate medication may be recommended with documented pain relief, an increase in functional improvement, a return to work and evidence of proper use of the medications. Supplemental doses of break-through medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. When discontinuing opiate pain medication a slow taper is recommended to wean the patient. Besides results of studies of opioids for musculoskeletalconditions (as opposed to cancer pain) generally recommend short use of opioids for severe cases, not to exceed 2 weeks, and do not support chronic use (MTUS page 82). CA-MTUS section on Opioids Ongoing Management recommends "Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Medical records from [redacted] dated 09/11/2013 stated "Since last visit patient went to ER September 8, 2013 [redacted] secondary to abdominal pain, back spasms, nausea and vomiting. States butrans was not authorized prescription on September 6, 2013, treated with fentanyl patch and Vicodin 7.5/500 mg/15 ml paid out of pocket. The claimant presently complains of low back pain that radiates to the left lower extremity. The patient also complains of neck pain that radiates to bilateral upper extremities. The patient's pain level is increased with average pain level of 7/10 with medications and 8/10 without medication. It does not appear as if all the prescribed pain medications are

effective, a need for re-assessment of ongoing use of opioids as recommended by the CA-MTUS guidelines which indicates "Ongoing use of opiate medication may be recommended with documented pain relief, an increase in functional improvement, a return to work and evidence of proper use of the medications. Therefore the request for 100 tablets of hydrocodone-acetaminophen (7.5 mg/500 mg) is not medically necessary.