

Case Number:	CM14-0152706		
Date Assigned:	09/22/2014	Date of Injury:	09/10/1996
Decision Date:	12/04/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/18/2014

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. The expert reviewer is Board Certified in Family Medicine 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 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 59-year-old male patient who reported an industrial injury to the head and neck on 9/10/1996, over 18 years ago, attributed to the performance of his usual and customary job tasks as a Sheriff's deputy. The patient is being treated for chronic pain. It is noted that the patient completed inpatient detoxification and noted the pain was increased. The patient was then placed on higher and higher doses of pain medication including Fentanyl patches. The patient was receiving a medication of 270 mg. The patient continued to complain of neck pain with muscle spasms. The patient reported that his pain was worse after reduction of opioids. The patient has had trials with OxyContin, Norco, Methadone, Vicodin, Demerol, and Fentanyl patches. His reported that the Fentanyl patches allow him to participate in activities of daily living. The patient received trigger point injections to the neck and upper back for muscle spasms and neck pain was also prescribed Flexeril 10 mg #90 and Lidoderm patches #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl patch 75mcg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306, Chronic Pain Treatment Guidelines Opioids Page(s): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6 pages 114-116; Official Disability Guidelines (ODG) Pain Chapter Opioids

Decision rationale: The patient has been documented to have gone through inpatient detoxification program; however, the patient has been provided Fentanyl patches and has returned to increasing doses of opioids for the reported chronic neck and upper back pain. The prescription for Fentanyl patches 75 mcg/hr. #15 is being prescribed as a long acting opioid analgesic for the treatment of chronic neck pain. There is objective evidence provided to support the continued prescription of opioid analgesics for chronic neck pain based on the objective findings documented. There is no documented functional improvement with the currently prescribed Fentanyl patches. The chronic use of Fentanyl patches is not recommended by the CA MTUS; the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic neck pain. The updated chapter of the ACOEM Guidelines and the third edition of the ACOEM Guidelines stated that both function and pain must improve to continue the use of opioids. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs and OTC analgesics for the treatment of chronic neck pain. Evidence-based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician, and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain states, "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician, and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also note, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function." Evidence-based guidelines recommend: Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks),

but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. The ODG states that chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. (Ballantyne, 2006) (Furlan, 2006) Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis). (Kalso, 2004) There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. (Martell-Annals, 2007) (ODG, Pain Chapter). There is no clinical documentation with objective findings on examination to support the medical necessity of Fentanyl patches for the treatment of chronic neck, upper back, or upper extremity pain. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with Fentanyl patches. There is no demonstrated medical necessity for the prescribed Fentanyl patches subsequent to graduating from an inpatient drug detoxification program for the cited diagnoses. Therefore, the request is not medically necessary and appropriate.