

Case Number:	CM14-0206471		
Date Assigned:	12/18/2014	Date of Injury:	08/10/2008
Decision Date:	02/06/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	12/10/2014

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 Internal Medicine, has a subspecialty in ENTER SUBSPECIALTY and is licensed to practice in New York. 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:

The patient is a 50 year old female with a date of injury of 08/10/2008. She noted neck pain, numbness and tingling in her upper extremities and low back pain. She filed a claim on 04/27/2011 noting her date of injury was 08/10/2008. On 08/12/2011 a cervical MRI revealed disc degenerative changes at C5-C6 and C6-C7. On 09/08/2011 the upper extremities EMG/NCS were negative. On 03/19/2013 he had neck pain radiating to shoulders, arms and forearms; worse on the right. On 03/28/2013 she had repeat EMG/NCS of both upper extremities that was negative. On 08/04/2014 urine test was positive to the prescribed hydrocodone. On 08/29/2014 a EMG/NCS of the lower extremities revealed bilateral S1 radiculopathy. On 09/22/2014 a lumbar MRI revealed mild disc protrusion at L3-L4 and L4-L5. On 11/24/2014 she had neck pain radiating to both upper extremities and low back pain. She bent down to get something from a drawer and had low back pain. She has been treated with Flexeril, Norco, Hydrocodone, chiropractic care, massage therapy and physical therapy. On 12/23/2014 she had decreased lumbar range of motion. She had neck pain, bilateral upper extremity pain, low back pain and sciatica. Straight leg raising was positive bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Butrans 5MCG/hr patch apply 1 patch top skin every 7 days #4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-going management. Page(s): 78 - 79.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines page 78, on-going management actions should include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). 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) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The patient has been treated with opiates for years (Hydrocodone, Norco) and the requested long term patch (Butran) is another opiate. There is insufficient documentation to substantiate that the above criteria for on-going opiate treatment have been met. As such the request is not medically necessary.