

Case Number:	CM15-0169398		
Date Assigned:	09/11/2015	Date of Injury:	10/18/2010
Decision Date:	10/08/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	08/27/2015

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: North Carolina
 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 49-year-old female, with a reported date of injury of 10-18-2010. The diagnoses include chronic pain syndrome, neck pain, cervical radiculopathy, cervical disc protrusion, cervical facet dysfunction, bilateral shoulder pain, occipital neuralgia, temporomandibular joint dysfunction, anxiety, depression, myalgia, headaches, and insomnia. Treatments and evaluation to date have included oral medications, Butrans patch (since at least 10-2014), a home exercise program, and a Prialt intrathecal trial. The diagnostic studies to date have included a urine drug screen in 11-2014, 12-10-2014, 01-05-2015, 02-04-2015, 05-2015, and 07-2015; and electrodiagnostic studies on 11-17-2014. The pain management re-evaluation report dated 07-08-2015 indicates that the injured worker stated that her pain was about the same. Her current pain level was rated 7-8 out of 10 without medications, and 5 out of 10 with medications. On 06-17-2015, the injured worker's pain was about the same, and she rated her pain 7 out of 10 without medications, and 4 out of 10 with medications. The physical examination showed positive Spurling's test; intact sensation to light touch; weakness in the right grip; tenderness to palpation over the cervical paraspinal musculature, upper trapezius, scapular border, lumbar paraspinal, and bilateral shoulders. It was noted that an MRI of the cervical spine was done on 04-02-2011 and 06-06-2011 which showed central disc protrusion at C4-5 with possible underlying annular tear, central disc protrusion at C5-6, left paracentral disc protrusion at C6-7, and central disc protrusion at C7-T1; and an electrodiagnostic study of the upper extremities on 11-21-2012 was normal. The injured worker's work status was not indicated. The medical report dated 06-10-2015 indicates that the injured worker remained on temporary total

disability. The request for authorization was dated 07-08-2015. The treating physician requested Butrans patch 20mcg #4, once weekly and a urinalysis to determine levels of prescriptions and the presence of any non-prescription drugs. On 07-28-2015, Utilization Review non-certified the request for Butrans patch 20mcg #4, once weekly due to no documentation of functional and vocational benefit with ongoing use of the medication, no documentation of a signed opiate contract, and the documentation of a urine drug screen dated 02-04-2015 with inconsistent results; and a urinalysis due to no indication that the injured worker was recommended for ongoing opioid use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Butrans patch 20mcg one weekly #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: 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 nonadherent) 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 nonopioid 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. When to Continue Opioids (a) If the patient has returned to work, (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

Urinalysis: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states: 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 nonopioid 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 California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids. The patient was on opioids at the time of request and therefore the request is medically necessary.

