

Case Number:	CM15-0186481		
Date Assigned:	09/28/2015	Date of Injury:	10/10/2002
Decision Date:	11/09/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	09/22/2015

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: Florida, New York, Pennsylvania
 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 41-year-old male who sustained an industrial injury on 10-2-2002. Diagnoses have included lumbar disc displacement without myelopathy, failed back syndrome, post-laminectomy syndrome, sciatica, and chronic pain. Documented treatment includes aqua-therapy, injections, H-wave, home exercise, and medication including Lidoderm 5 percent patch, and Butrans patch stated to provide 40 percent pain decrease and improvement in tolerance for walking and standing. Pain ratings were not provided. On 6-15-2015 Butran patch was reported as "somewhat effective and not adequately alleviating his pain." It was noted that previous medications had given him stomach discomfort. Initial implementation date of the Butran and Lidoderm patches are not provided in the documentation, but he has been using them for at least six months prior to the determination of this request. The injured worker has been authorized for an intrathecal opioid pain pump 9-29-2015. As of 9-3-2015, the injured worker continues to complain of chronic low back pain stated as "axial in nature" and becomes worse with activity. The physician noted normal muscle tone, lumbar spasm and guarding. The plan of care includes a request for 4 count Butrans Patches, and 90 count Lidoderm 5 percent patches which were denied on 9-17-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Butrans Patch 10mcg #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): Buprenorphine, Opioids, criteria for use, Opioids for chronic pain, Opioids, long-term assessment.

Decision rationale: DOI was 120/Oct 02. The injury was to the back and right buttock. The member experiences severe LBP radiating down the right leg associated with numbness and tingling. The member has failed surgical intervention as well as spinal cord stimulation and is reported to have been approved for an implantable pain pump after a successful Fentanyl infusion. The member is reported to have had troubles tolerating various medications or found them to be ineffective. The member is no using the 10-microgram patch replacing it every 7 days. He remains on a PPI for reflux symptoms. His neuropsychologist reported the member complained of incapacitating migraine on this dose and recommended a return to the 5-microgram patch. The Butrans had previously been Non-Certified and recommended to be weaned some time prior to a UR 31Jul15 for a lack of objective functional improvement and was again Non-Cert at that review. Butrans is primarily 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. A schedule-III controlled substance, Buprenorphine is a partial agonist at the mu-receptor (the classic morphine receptor) and an antagonist at the kappa receptor (the receptor that is thought to produce alterations in the perception of pain, including emotional response). In recent years, Buprenorphine has been introduced in most European countries as a transdermal formulation ("patch") for the treatment of chronic pain. 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 anti-hyperalgesic effect (partially due to the effect at the kappa-receptor). Anti-inflammatories are the traditional first line of treatment to reduce pain so activity and functional restoration can resume Opioids, for long-term use, cannot be supported, as there is a lack of evidence to allow for a treatment recommendation. A meta-analysis found that opioids were more effective than placebo for reducing pain intensity but the benefit for physical function was small and was considered questionable for clinical relevance. Opioids can be recommended on a trial basis for short-term use after there has been evidence of failure of first-line medication options such as acetaminophen or NSAIDs when there is evidence of moderate to severe pain. The use of opioids in this circumstance should be in addition to rather than a replacement for first line medications. If chronic use is entertained then before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities. Continuation of the use of opioids would be best assessed on the basis of a return to work with evidence for improved functioning and reduced pain. The primary risk with continued use is that 36 to 56% of users have a lifetime risk for substance use disorders. Additionally there is the risk of diversion, tolerance and hyperalgesia resulting in gradual increases in medication dosing and evidence for decreasing benefits. Discontinuation of Opioids is recommended for the following situations: (a) If there is no overall improvement in function, unless there are extenuating circumstances. (b) Continuing pain with the evidence of intolerable adverse affects. (c) Decrease in functioning. (d) Resolution of pain. (e) If serious non-adherence is occurring. (f) The patient requests discontinuing. The member passes all the tests above per the notes provided for review except for any objective evidence for functional improvement. The level of pain has consistently remained at 9/10 without Butrans and 5/10 with. The member remains at home, out of work. The medication had been Non-Certified

twice before with recommendations made to wean the medication. The UR Non-Cert is supported; the request is not medically necessary.

Lidoderm Patch 5% #90: 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): Lidoderm (lidocaine patch), Topical Analgesics.

Decision rationale: These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. In the management of chronic pain, topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. It cannot be recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. Therefore, it would not be indicated for use in chronic pain. There is no evidence for use of medications listed as first line therapy such as anti-depressants and anti-epileptics (other than Gabapentin). Nor was there supporting evidence for objective functional improvement on examination rather than subjective. This medication had previously been non-certified for use for similar reasons as far back as 13Oct14. Based on the primary indication for this medication, the previous non-certification and persistent lack of evidence for objective functional improvement the current Non-Cert is sustained; the request is not medically necessary.