

<b>Case Number:</b>	CM15-0189959		
<b>Date Assigned:</b>	10/02/2015	<b>Date of Injury:</b>	01/15/1998
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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: California, Indiana, New York  
 Certification(s)/Specialty: Internal Medicine

### 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 63 year old female, who sustained an industrial injury on 1-15-98. Medical records indicate that the injured worker is undergoing treatment for cervical herniated nucleus pulposus, cervical foraminal stenosis, cervical disc degeneration, cervical radiculopathy, right upper extremity complex regional pain syndrome, cervicogenic headaches, generalized anxiety disorder and major depressive disorder. The injured worker was rioted to be permanent and stationary. The injured workers current work status was not identified. On (9-3-15) the injured worker complained of significant pain in the right upper extremity. The injured worker was receiving acupuncture treatments, which were helpful but not long lasting. The injured worker also noted increased anxiety and depression related to her ongoing condition. Examination of the cervical spine revealed a decreased range of motion in all planes. Cervical paraspinal and trapezius muscles exhibited muscle spasms with trigger points. Allodynia was noted in the right shoulder and right upper extremity. Right shoulder range of motion was decreased due to pain. The injured workers pain levels were not provided in the subsequent progress reports (9-3-15, 8-17-15 and 5-21-15). Treatment and evaluation to date has included medications, MRI of the cervical spine, physical therapy, occipital nerve blocks, acupuncture treatments, psychological sessions, sacroiliac joint injections, home exercise program and a cervical fusion. Current medications include Butrans patch (since at least May of 2015), Gabapentin, Nuvigil, Hydrocodone, Hydromorphone and Norco (since at least 2010). The request for authorization dated 9-10-15 includes requests for Butrans patch 15 mcg-7 hour # 4, Norco 10-325 mg # 120 and Hydromorphone # 90. The Utilization Review documentation dated 9-21-15 modified the request to Butrans patch 15 mcg-7 hour # 3 (original request # 4),

Norco 10-325 mg # 108 (original request 120) and Hydromorphone # 81 (original request # 90).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Butrans patch 15 mcg/7 hr, Qty 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Buprenorphine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Butrans (Buprenorphine).

**Decision rationale:** Pursuant to the Official Disability Guidelines, Butrans patch 15mcg/hr every 7 days #4 is not medically necessary. Butrans is recommended as an option for treatment of chronic pain in selected patients (not a first-line drug). Suggested populations are patients with hyperalgesia complement pain; patients with centrally mediated pain; patients with neuropathic pain; patients at high risk of non-adherence with standard opiate maintenance; and for analgesia in patients who have previously been detoxified from other high-dose opiates. In this case, the injured worker's working diagnoses are cervical pain/dystonia/muscle spasm; right upper extremity CRPS/C-5 - C6 radiculopathy; and cervicogenic headaches/migraines. Date of injury is January 15, 1998. Request for authorization is September 10, 2015. According to a May 21, 2015 pain management progress note, current medications include gabapentin, Topamax, zolpidem, Butrans patch, hydrocodone and Nuvigil. There is no documentation of hydromorphone in the record. According to a July 27, 2015 initial orthopedic evaluation, the documentation indicates the injured worker has detoxed from pain medications and is only on Subutex. The injured worker has been taking some narcotics over the past month. This provider is also prescribing baclofen plus other non-opiate medications. According to an August 17, 2015 progress note, subjective complaints include right upper extremity pain and migraine headaches. The medications remain the same and there is no hydromorphone documented in the medical record. It appears from the documentation two providers are prescribing different opiate-based medications without knowledge of the other provider. The morphine equivalent dose (according to the utilization review) is 136 (up to 120 is normal). The documentation does not demonstrate objective functional improvement to support ongoing Butrans patch. There were no risk assessments or detailed pain assessments. There has been no attempt that weaning Butrans. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, documentation indicating two providers are prescribing different opiate medications without knowledge of the other provider, no urine drug screens or risk assessments, no detailed pain assessments and no attempt at weaning Butrans, Butrans patch 15mcg/hr every 7 days #4 is not medically necessary.

**Norco 10/325 mg Qty 120:** 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Opioids.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Norco 10/325mg #120 is not medically necessary. Ongoing, chronic opiate use requires an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. A detailed pain assessment should accompany ongoing opiate use. Satisfactory response to treatment may be indicated patient's decreased pain, increased level of function or improve quality of life. The lowest possible dose should be prescribed to improve pain and function. Discontinuation of long-term opiates is recommended in patients with no overall improvement in function, continuing pain with evidence of intolerable adverse effects or a decrease in functioning. The guidelines state the treatment for neuropathic pain is often discouraged because of the concern about ineffectiveness. In this case, the injured worker's working diagnoses are cervical pain/dystonia/muscle spasm; right upper extremity CRPS/C-5 - C6 radiculopathy; and cervicogenic headaches/migraines. Date of injury is January 15, 1998. Request for authorization is September 10, 2015. According to a May 21, 2015 pain management progress note, current medications include gabapentin, Topamax, zolpidem, Butrans patch, hydrocodone (Norco) and Nuvigil. There is no documentation of hydromorphone in the record. According to a July 27, 2015 initial orthopedic evaluation, the documentation indicates the injured worker has detoxed from pain medications and is only on Subutex. The injured worker has been taking some narcotics over the past month. This provider is also prescribing baclofen plus other non-opiate medications. According to an August 17, 2015 progress note, subjective complaints include right upper extremity pain and migraine headaches. The medications remain the same and there is no hydromorphone documented in the medical record. It appears from the documentation two providers are prescribing different opiate-based medications without knowledge of the other provider. The morphine equivalent dose (according to the utilization review) is 136 (up to 120 is normal). The documentation does not demonstrate objective functional improvement to support ongoing Norco. There were no risk assessments or detailed pain assessments. There has been no attempt at weaning Norco. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, documentation indicating two providers are prescribing different opiate medications without knowledge of the other provider, no urine drug screens or risk assessments, no detailed pain assessments and no attempt at weaning Norco, Norco 10/325mg #120 is not medically necessary.

**Hydromorphone Qty 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): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Opioids.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Hydromorphone 8mg # 90 is not medically necessary. Ongoing, chronic opiate use requires an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. A detailed pain assessment should accompany ongoing opiate use. Satisfactory response to treatment may be indicated patient's decreased pain, increased level of function or improve quality of life. The lowest possible dose should be prescribed to improve pain and function. Discontinuation of long-term opiates is recommended in patients with no overall improvement in function, continuing pain with evidence of intolerable adverse effects or a decrease in functioning. The guidelines state the treatment for neuropathic pain is often discouraged because of the concern about ineffectiveness. In this case, the injured worker's working diagnoses are cervical pain/dystonia/muscle spasm; right upper extremity CRPS/C-5 - C6 radiculopathy; and cervicogenic headaches/migraines. Date of injury is January 15, 1998. Request for authorization is September 10, 2015. According to a May 21, 2015 pain management progress note, current medications include gabapentin, Topamax, zolpidem, Butrans patch, hydrocodone (Norco) and Nuvigil. There is no documentation of hydromorphone in the record. According to a July 27, 2015 initial orthopedic evaluation, the documentation indicates the injured worker has detoxed from pain medications and is only on Subutex. The injured worker has been taking some narcotics over the past month. This provider is also prescribing baclofen plus other non-opiate medications. According to an August 17, 2015 progress note, subjective complaints include right upper extremity pain and migraine headaches. The medications remain the same and there is no hydromorphone documented in the medical record. It appears from the documentation two providers are prescribing different opiate-based medications without knowledge of the other provider. The morphine equivalent dose (according to the utilization review) is 136 (up to 120 is normal). The documentation does not provide a clinical discussion or rationale for hydromorphone. The documentation does not demonstrate objective functional improvement to support ongoing hydromorphone. There were no risk assessments or detailed pain assessments. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, documentation indicating two providers are prescribing different opiate medications without knowledge of the other provider, no urine drug screens or risk assessments, and no detailed pain assessments, Hydromorphone 8mg # 90 is not medically necessary.