

Case Number:	CM14-0176967		
Date Assigned:	10/30/2014	Date of Injury:	10/08/2008
Decision Date:	12/05/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/24/2014

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 47-year-old female who reported an industrial injury to her lower back on 10/8/2008, over six (6) years ago, attributed to the performance of her usual and customary job tasks reported as a slip and fall. The patient complained of pain to the pubic symphysis area, distal pelvic region, hips, and SI joint subsequent to a slip and fall at work. The patient received periodic injections to the symphysis pubis and received an SI joint injection. The patient has been treated with physical therapy; chiropractic care; medications; and work restrictions. The patient is prescribed fentanyl patches 75 mcg/hour every 48 hours along with Percocet tablets. The patient is moving from the area and has retired from her job. The objective findings on examination included no apparent distress; demeanor is engageable; cognition was grossly intact; transfer station to station without assistance; normal gait; does not demonstrate Frank weakness on ambulation. The diagnosis was chronic pain on an industrial basis affecting the back and pubic symphysis. The treatment plan included fentanyl patches 75 mcg/hour #14 and transfer care to [REDACTED] in [REDACTED].

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Fentanyl Patches 75mcg #15: Upheld

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

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: Evidence-based guidelines recommend short-term use of opioids for the management of chronic nonmalignant moderate to severe pain. Long-term use is not recommended for nonmalignant pain due to addiction, dependency, intolerance, abuse, misuse, and/or side effects. Ongoing opioid management criteria are required for long-term use with evidence of reduce pain and improve function as compared to baseline measurements or a return to work. The prescription for Fentanyl patches 75 mcg/hour #15 was prescribed as a long acting opioid analgesic for the treatment of chronic back pain contrary to the recommendation of evidence-based guidelines. There is no objective evidence provided to support the continued prescription of opioid analgesics for chronic back 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 back 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 (over the counter) analgesics for the treatment of chronic back 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 state, "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 [REDACTED] 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 (greater than 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 percent to 56 percent. 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 [REDACTED] 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 percent 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 back 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.