

Case Number:	CM14-0179373		
Date Assigned:	11/03/2014	Date of Injury:	04/16/2010
Decision Date:	12/09/2014	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/29/2014

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 55-year-old female patient who reported an industrial injury on 5/12/2010, over 4 years ago, attributed to the performance of her usual and customary job tasks attributed to the reported cumulative trauma. The patient complained of right knee pain and difficulty with walking. The patient also complained of low back pain. The patient has the underlying diagnoses of fibromyalgia and a diagnosis in of a prior frozen right shoulder. The objective findings on examination included markedly antalgic gait; severe right knee tenderness along the medial joint line with positive McMurray's sign; restricted painful right frozen shoulder with positive impingement; right upper extremity weakness. The diagnoses included overuse syndrome; status post (s/p) bilateral carpal tunnel release (CTR); s/p DQR left; right frozen shoulder; right knee internal derangement; chronic pain syndrome; fibromyalgia; sleep disorder; sexual dysfunction; gastritis/gastroesophageal reflux disease (GERD) /dysphasia; new onset hypertension; and depressive disorder. It was noted that the AME in orthopedics had recommended future medical care to include right knee arthroscopy. The treatment plan was for an updated right knee MRI with orthopedic follow-up and consideration of knee arthroscopy; right knee intra-articular steroid injection; and topical anti-inflammatories as it was reported that the patient was intolerant to all oral analgesics. The patient was prescribed Butrans patch 10 mcg one q. week #10 and Pennsaid 2% two pumps bid for the right knee.

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 Treatment Guidelines Buprenorphine.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 47-47 and 300-06, Chronic Pain Treatment Guidelines Opioids Page(s): 74-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter- opioids and American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6 pages 114-16

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 Butrans patches 10 mcg/hr for seven (7) days #4 for long acting pain relief is being prescribed as an opioid analgesic for the treatment of chronic knee and back pain. There is no objective evidence provided to support the continued prescription of opioid analgesics for chronic pain reported to the low back. There is no documented functional improvement from this opioid analgesic and the BuTrans should be discontinued. The ACOEM Guidelines and CA MTUS do not recommend long acting opioids for mechanical low back/knee pain. California MTUS Chronic Pain Medical Treatment Guidelines section on Opioids; Ongoing Management recommends; "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects." The medical records provided for review do not document evidence of functional improvement due to the use of BuTrans. The opportunity for weaning was provided. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses and effects of the industrial claim. There is no documented sustained functional improvement. There is no medical necessity for opioids directed to chronic mechanical knee and back pain. The prescription for Butrans is being prescribed as opioid analgesics for the treatment of chronic neck and knee pain against the recommendations of the ACOEM Guidelines. There is no objective evidence provided to support the continued prescription of opioid analgesics for chronic back pain four (4) years after the initial date of injury (DOI). There is no demonstrated medical necessity for the prescription of BuTrans for chronic back and knee pain. The chronic use of BuTrans is not recommended by the CA MTUS; the ACOEM Guidelines or the Official Disability Guidelines for the long-term treatment of chronic pain and is only recommended as a treatment of last resort for intractable pain. 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 non-steroidal anti-inflammatory drugs (NSAIDs) for the treatment of chronic pain. The current prescription of opioid analgesics is not consistent with evidence-based guidelines based on intractable pain. The ACOEM Guidelines updated chapter on chronic pain states, "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 WHO 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." There is no demonstrated medical necessity for the prescription of Butrans patches 10 mcg/hr #4 for the cited orthopedic diagnoses.