

<b>Case Number:</b>	CM14-0210633		
<b>Date Assigned:</b>	12/23/2014	<b>Date of Injury:</b>	10/13/2010
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2014

### 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. 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

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

40 year old male welder injured at work on 13 Oct 2010, 27 Oct 2008 and 6 Dec 2008. He has been diagnosed with chronic pain syndrome, myalgia/myositis, lumbosacral radiculitis, intervertebral disc disorder without myelopathy and degenerative lumbosacral disc disease with chronic low back pain. His provider believes his pain is a combination of nociceptive and neuropathic pain. The patient also developed insomnia and depression secondary to his work-related injuries. Comorbid conditions include obesity (BMI 32.4), gastroesophageal reflux disease and diabetes. At his last provider evaluation (16 Dec 2014) he complained of continued back pain helped by use of narcotic medications (reduced pain from 6/10 to 4/10) and TENS units. The pain worsens with walking and lying down. Exam showed normal gait, normal lower extremity strength, decreased Achilles reflexes to 1/4 but normal patellar reflexes, intact sensation in lower extremities, normal straight leg raise bilaterally, pain on flexion and extension of the back and tenderness of the thoracic and lumbar paraspinal muscles. Urine toxicology screen (11 Sep 2014) was negative. Lumbar MRI (2 Mar 2011) showed degenerative bony changes at L4-5 and L5-S1 and degenerative disc changes at L5-S1. Treatment has included physical therapy, H-wave therapy, TENS, lumbar epidural steroid injections and medication (Vicodin, Percocet, Medrox cream, Norco, Ultram, Anaprox, Flexeril, Prilosec, Lunesta, Lido-Capsaicin-Menthol-Methyl Salicylate lotion).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Butrans 10mcg / hour patch #4 (prescribed 11-18-14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 47-8, 299, 308, Chronic Pain Treatment Guidelines Part 2 Page(s): 60-1, 74-96, 111-13.

**Decision rationale:** Butrans (buprenorphine) patch is classified as an opioid medication. As a patch it is formulated for use as a topical preparation. It is recommended for moderate to moderately severe pain. According to the MTUS, opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. The use of topical analgesics is largely experimental and is primarily recommended for neuropathic pain when trials of antidepressants or anticonvulsants have failed. Success of opioid therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction, overdose and death. The pain guidelines in MTUS directly address this issue and have a number of recommendations to identify when addiction develops and to prevent addiction from occurring. The present provider is appropriately monitoring this patient and notes the improvement in patient's function with the use of opioid preparations. However, the records do not show any use of other first-line medication therapies (antidepressants, anticonvulsants) for neuropathic pain prior to initiation of opioid treatment nor since beginning the opioid treatment. Since the MTUS specifically recommends chronic use of opioids for neuropathic pain only after failure of the safer, first-line medications continued use of chronic opioid therapy is contraindicated. Chronic use of oral, not topical, opioid pain medications for moderate to severe nociceptive pain is considered by the MTUS to be the standard of care. It defines nociceptive pain as pain due to continual injury such as from cancer. The records submitted for review do not support this characterization of this patient's pain. Medical necessity for use of a topical opioid preparation for this patient is not indicated.