MAXIMUS Federal Services

| Case Number: | CM15-0012090 | | |
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| Date Assigned: | 01/29/2015 | Date of Injury: | 11/29/2004 |
| Decision Date: | 03/24/2015 | UR Denial Date: | 12/20/2014 |
| Priority: | Standard | Application Received: | 01/21/2015 |

## 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
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:

This 32-year-old beer supplier employee reported a low back injury after slipping as he was stacking cases of beer on 11/29/2004. He has had a total of three lumbar spine surgeries on 9/16/05, 10/18/07 and 9/13/13, and a future fourth surgery appears possible. Current diagnoses include chronic pain syndrome, lumbar spinal stenosis, degenerative disc disease and lumbar post-laminectomy syndrome. Treatment to date has included oral and transdermal pain medication, physical therapy and surgery. The patient has been taking/applying hydrocodone/acetaminophen and fentanyl patches since at least 06/13/2011. The dosage has been constant except for an increase in frequency of the fentanyl 50 mcg patch to every 48 hours rather than every 72 hours beginning 1/27/14. The patient did not work for a prolonged period after his injury, then attended school and subsequently found a desk job, which is reported to perform full time. The records contain the results of multiple drug screens, all of which are positive for marijuana metabolites, which has never been addressed by the primary treater. In addition there are two screens which were negative for opioids dated 10/13/14 and 12/8/14. In both cases the provider accepted the explanation that the patient had not taken hydrocodone/acetaminophen since the previous afternoon, since he had to drive to his doctor's appointment. In a progress note dated 12/14/2014, the injured worker reported continued back pain with associated numbness and tingling that was rated as 10/10 without medication and 6/10 with medication. Objective physical examination findings were notable for an antalgic gait, bilateral tenderness of the paraspinal region at L3 and the iliolumbar region and decreased sensation of the knee and medial leg (L4 distribution) and a positive seated straight leg raise on

the left. The physician requested authorization for refills of Fentanyl patches and Hydrocodone/Acetaminophen. Two prescriptions of Fentanyl 50 mcg #15 were requested, one prescription of hydrocodone/acetaminophen (HC/APAP) 10/325 #150, and another for HC/APAP #180 were requested. On 12/20/2014, Utilization Review non-certified a request for fentanyl patches, noting that an additional prescription of fentanyl was not warranted as the injured worker was provided with an adequate supply to allow continued access, modified a request for Hydrocodone/Acetaminophen 10/325 mg from #180 to #126 between 12/14/2014 and 02/15/2015 and modified a request for Hydrocodone/Acetaminophen 10/325 mg from #150 to #105 between 12/14/2014 and 02/15/2015 noting that there was no documentation of improved function and pain levels and that the medication should continue to be slowly tapered. MTUS guidelines were cited.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Fentanyl 50mcg/hr #15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system); When to Continue Opioids;.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids, pages 76-77; Opioids for neuropathic pain, page 82; Opioids, long-t.

**Decision rationale:** Fentanyl is a very powerful opioid analgesic. The guidelines above state that opioids should not be started without an evaluation of the patient’s current status in terms of pain control and function. An attempt should be made to determine in the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific functional goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. If long-term opioids are used, a reassessment should be made at 6 months, and repeated every 6 months thereafter. The reassessment should include documentation of pain and function levels in comparison to baseline, an assessment of adverse side effects, and consideration of psychological consultation or of using a screening instrument for abuse/addiction. Pain treatment agreements are recommended and urine drug screens may be required. The consequences of non-adherence to treatment agreements should be outlined. The clinical documentation in this case does not support the continued provision of fentanyl (or of any opioid) to this patient. Although there is documentation that the patient has returned to sedentary work and can sit for longer periods with pain medications that without, these factors are not documented as goals of treatment, and there are no documented functional goals for continued treatment. A major component of this patient's pain appears to be neuropathic, given his repeatedly documented radicular findings. Neuropathic pain does not necessarily respond

well to opioids, and his rather unimpressive decrease in pain with opioid use may reflect this. There is no evidence that the provider is reassessing this patient every six months, and in particular that he is reassessing for abuse or diversion potential. Marijuana use is a red flag for abuse, and should have been addressed in the patient's pain contract. In fact, lack of use of hydrocodone within the previous 18-24 hours is not a reasonable explanation of a urine drug screen that is negative for hydrocodone or its metabolites. This has occurred twice, which should have raised questions about diversion, and did not. Based on the MTUS citations above and on the clinical documentation provided for my review, fentanyl 25 mcg patch, #15 is not medically necessary. It is not medically necessary because the patient's pain has not been appropriately evaluated for a neuropathic component, because no ongoing functional goals for opioid use are documented, and because issues of possible abuse and diversion have not been addressed.

**Hydrocodone/acetaminophen 10/325mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone (Vicodin, Lortab); When to Continue Opioids; Opioids f.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids, pages 76-77; Opioids for neuropathic pain, page 82; Opioids, long-t.

**Decision rationale:** Hydrocodone/acetaminophen 10/325 contains 10 mg of hydrocodone combined with 325 mg of acetaminophen. This drug's common brand name is Norco. Hydrocodone is an opioid analgesic. The guidelines above state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine in the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific functional goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. If long-term opioids are used, a reassessment should be made at 6 months, and repeated every 6 months thereafter. The reassessment should include documentation of pain and function levels in comparison to baseline, an assessment of adverse side effects, and consideration of psychological consultation or of using a screening instrument for abuse/addiction. Pain treatment agreements are recommended and urine drug screens may be required. The consequences of non-adherence to treatment agreements should be outlined. The clinical documentation in this case does not support the continued provision of hydrocodone/acetaminophen (or of any opioid) to this patient. Although there is documentation that the patient has returned to sedentary work and can sit for longer periods with pain medications that without, these factors are not documented as goals of treatment, and there are no documented functional goals for continued treatment. A major component of this patient's pain appears to be neuropathic, given his repeatedly documented radicular findings. Neuropathic pain does not necessarily respond well to opioids, and his rather

unimpressive decrease in pain with opioid use may reflect this. There is no evidence that the provider is reassessing this patient every six months, and in particular that he is reassessing for abuse or diversion potential. Marijuana use is a red flag for abuse, and should have been addressed in the patient's pain contract. In fact, lack of use of hydrocodone within the previous 18-24 hours is not a reasonable explanation of a urine drug screen that is negative for hydrocodone or its metabolites. This has occurred twice, which should have raised questions about diversion, and did not. Based on the MTUS citations above and on the clinical documentation provided for my review, hydrocodone/acetaminophen 10/325 #180 is not medically necessary. It is not medically necessary because the patient's pain has not been appropriately evaluated for a neuropathic component, because no ongoing functional goals for opioid use are documented, and because issues of possible abuse and diversion have not been addressed.

**Hydrocodone/acetaminophen 10/325 #150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone (Vicodin, Lortab); When to Continue Opioids; Opioids f.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids, pages 76-77; Opioids for neuropathic pain, page 82; Opioids, long-t.

**Decision rationale:** Hydrocodone/acetaminophen 10/325 contains 10 mg of hydrocodone combined with 325 mg of acetaminophen. This drug's common brand name is Norco. Hydrocodone is an opioid analgesic. The guidelines above state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine in the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific functional goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. If long-term opioids are used, a reassessment should be made at 6 months, and repeated every 6 months thereafter. The reassessment should include documentation of pain and function levels in comparison to baseline, an assessment of adverse side effects, and consideration of psychological consultation or of using a screening instrument for abuse/addiction. Pain treatment agreements are recommended and urine drug screens may be required. The consequences of non-adherence to treatment agreements should be outlined. The clinical documentation in this case does not support the continued provision of hydrocodone/acetaminophen (or of any opioid) to this patient. Although there is documentation that the patient has returned to sedentary work and can sit for longer periods with pain medications that without, these factors are not documented as goals of treatment, and there are no documented functional goals for continued treatment. A major component of this patient's pain appears to be neuropathic, given his repeatedly documented radicular findings. Neuropathic pain does not necessarily respond well to opioids, and his rather

unimpressive decrease in pain with opioid use may reflect this. There is no evidence that the provider is reassessing this patient every six months, and in particular that he is reassessing for abuse or diversion potential. Marijuana use is a red flag for abuse, and should have been addressed in the patient's pain contract. In fact, lack of use of hydrocodone within the previous 18-24 hours is not a reasonable explanation of a urine drug screen that is negative for hydrocodone or its metabolites. This has occurred twice, which should have raised questions about diversion, and did not. Based on the MTUS citations above and on the clinical documentation provided for my review, hydrocodone/ acetaminophen #150 is not medically necessary. It is not medically necessary because the patient's pain has not been appropriately evaluated for a neuropathic component, because no ongoing functional goals for opioid use are documented, and because issues of possible abuse and diversion have not been addressed.