

Case Number:	CM15-0117242		
Date Assigned:	06/26/2015	Date of Injury:	07/09/2011
Decision Date:	08/14/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	06/17/2015

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: New York

Certification(s)/Specialty: Pediatrics, 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 53 year old female, who sustained an industrial injury on July 9, 2011. She reported feeling a pulling sensation from her neck into her right upper extremity with an electric shocking-like sensation. The injured worker was diagnosed as having chronic pain not elsewhere classified, neck pain, and pain in shoulder joint, cervicobrachial syndrome, and cervical spinal stenosis. On July 8, 2012, an MRI of the right shoulder revealed moderate rotator cuff tendinosis and fraying without a partial or full thickness tear, a focal superior labral tear, mild to moderate acromioclavicular joint degenerative changes, and mild subacromial bursitis. On August 2, 2013, electromyography of the right upper extremity revealed evidence of a chronic right cervical 7 radiculopathy and a superimposed mild right carpal tunnel syndrome. On June 27, 2014, an MRI of the cervical spine revealed multilevel spondylosis and cervical straightening, diminished cerebral spinal fluid buffer about the cord at cervical 4-5 and cervical 5-6, significant neural foraminal narrowing at right cervical 5-6, bilateral cervical 6-7, and right greater than left cervical 4-5. On April 7, 2015, a urine drug screen was performed and the findings were negative for amphetamines, barbiturates, benzodiazepines, cannabinoids, Ecstasy, ethyl alcohol, methadone metabolite, opiates, oxycodone, Phencyclidine, and tricyclics. On April 23, 2013, she underwent a right shoulder surgery. Treatment to date has included cervical epidural steroid injections, right shoulder steroid injection, hand physical therapy, physical therapy for the neck, postoperative physical therapy for the shoulder, acupuncture, a home transcutaneous electrical nerve stimulation (TENS) unit, a home exercise program, psychotherapy, and medications including antidepressant, long-acting opioid analgesic, topical

analgesic, muscle relaxant, proton pump inhibitor, non-steroidal anti-inflammatory, and anti-epilepsy. There were no noted previous injuries or dates of injury. Comorbid diagnoses included history of hypertension and diabetes mellitus. On April 7, 2015, the injured worker complains of chronic neck, shoulder, and upper extremity pain. She complains of anxiety and depression. She failed a trial of full duty return to work with a different employer. Repetitive motions of the right upper extremity aggravated her pain and she was unable to tolerate the return to work. She is not currently working. She reports wanting to discontinue morphine due to it causes dizziness. The physical exam revealed was unremarkable. She continues with psychological treatment for concurrent depressive symptoms. The treating physician noted that the Controlled Substance Utilization Review and Evaluation System (CURES) report from April 7, 2015 indicated that the injured worker was receiving pain medication from this office only. Her current work restrictions include no lifting greater than 10 pounds, no repetitive right upper extremity movements, and no work above the level of the right shoulder. The treatment plan includes discontinuing the Morphine Sulfate ER and a trial of Butrans patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

Butrans 5mcg/hr patch #4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine; Opioids Page(s): 26-27; 74-96.

Decision rationale: The long-term usage of opioid therapy is discouraged by the California Medical Treatment Utilization Schedule (MTUS) guidelines unless there is evidence of "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The California Medical Treatment Utilization Schedule (MTUS) guidelines recommends Butrans (Buprenorphine) for treatment of "opiate addiction and as option for chronic pain, especially after detoxification in patients who have a history of opiate addiction". Per ODG guidelines, Butrans is recommended for certain populations including "patients with a hyperalgesic component to pain, patients with centrally mediated pain, patients with neuropathic pain, and patients at high-risk of non-adherence with standard opioid maintenance. There was lack of physician documentation of the least reported pain over the period since last assessment, average pain, the intensity of pain after taking the opioid (Morphine sulfate ER), how long it takes for pain relief, how long pain relief lasts, improvement in pain, and improvement in function to support the change to a different opioid. In addition, the California Medical Treatment Utilization Schedule (MTUS) guidelines also details indications for discontinuing opioid medication, such as serious non-adherence or diversion. There was lack of evidence of an updated and sign contract between the injured worker and physician, risk assessment profile, and

attempt at weaning/tapering. The urine drug screen from April 7, 2015 was negative for opiates, which inconsistent with the prescribed opiate therapy. The injured worker is diagnosed with and treated for anxiety and depression. These are considered red flags and have not been shown to have good success with opioid therapy. The provider does not detail extenuating circumstances for opioid usage in the context of anxiety and depression. Therefore, the request for Butrans is not medically necessary.