

Case Number:	CM15-0177940		
Date Assigned:	09/18/2015	Date of Injury:	04/04/1997
Decision Date:	10/21/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/09/2015

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: North Carolina

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:

The injured worker is a 55 year old male who sustained an industrial injury on 4-4-97. Diagnoses are noted as chronic low back pain-degenerative lumbar spondylosis, chronic low back pain-myofascial pain syndrome, pain disorder with psychological-general medical condition, and insomnia-persistent due to chronic pain. Previous treatment includes analgesic medicines, physical therapy, behavioral medicine, and cortisone injections. In a progress report dated 8-26-15, the physician notes the injured worker has chronic low back pain due to degenerative spondylosis of the lumbar spine. Continued pain is worst in the low back and worse with cold, wet weather. Current pain medications are noted to improve his level of function. It is noted he continues with chronic pain with both nociceptive and affective components and that he has partial pain relief with current analgesic medicines. The physician notes he is deemed to be not a good surgical candidate because of multilevel involvement of the spine by the spondylosis. Current medications are Fentanyl Patch 100mcg #15, Fentanyl Patch 75mcg #15, Norco 10-325 #150, Soma 350mg #120, Ibuprofen 800mg #100, and testosterone. He has tried and failed Cymbalta. Before pain medication, pain is rated at 9 out of 10 and after pain medication, pain is rated at 4.5 out of 10. Functional status reported before pain medication is he can drive 30 minutes, sit 30 minutes, walk 15 minutes and lift 5 pounds. After pain medication, he can drive 50 minutes, sit 60 minutes, walk 40 minutes, and lift 15 pounds. A urine drug screening 5-28-15 shows compliance with medication. An opioid contract is noted to be signed. A wean-taper was performed in 5-2014; a partial taper was accomplished and then there was a marked increase in pain, which necessitated a return to full dose analgesic medication. Work status is noted as a

permanent disability. A request for authorization is dated 9-2-15. The requested treatment of Fentanyl Patch 100mcg #15 was modified to Fentanyl Patch 100mcg #10 and Fentanyl Patch 75mcg #15 was modified to Fentanyl Patch 75mcg #10 on 9-8-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl patch 100mcg, #15: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include:

- (a) Prescriptions from a single practitioner taken as directed and all prescriptions from a single pharmacy.
- (b) The lowest possible dose should be prescribed to improve pain and function.
- (c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)
- (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.
- (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.
- (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).
- (g) Continuing review of overall situation with regard to non-opioid means of pain control.
- (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work. (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use

of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is documentation of significant subjective improvement in pain such as VAS scores decreased from a 9/10 to a 4.5/10. There is objective measure of improvement in function or activities due to medication. Work status is not currently working. For these reasons, all the criteria set forth above of ongoing and continued used of opioids have been met. Therefore, the request is medically necessary.

Fentanyl patch 75mcg, #15: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include:

(a) Prescriptions from a single practitioner taken as directed and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain dairy that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids:(a) If the patient has returned to work(b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003)

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