

Case Number:	CM13-0002728		
Date Assigned:	12/04/2013	Date of Injury:	04/07/2009
Decision Date:	01/15/2014	UR Denial Date:	07/03/2013
Priority:	Standard	Application Received:	07/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation 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 physician 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:

The patient is a 47-year-old female who reported an injury on 04/07/2009. Her diagnoses include mid to lower thoracic strain and mild thoracic degenerative facet joint disease. Her symptoms include mid thoracic pain that radiates to both sides. Physical examination findings include flexion of the lumbar spine to 90 degrees, thoracic spine rotation 25 degrees bilaterally with pain, thoracic spine left bending 60 degrees bilaterally with pain, tenderness of the left and right mid thoracic spine to palpation, and normal neurological findings. In his 08/12/2013 note, [REDACTED] stated that the patient was to be weaned off the narcotic medications and non-narcotic over-the-counter medications will be provided during the exacerbations of her symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl patches: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The patient's medications were noted to include fentanyl patches 12 mcg every 3 days and Norco 10/325 mg 1 every 4 hours as needed for pain. California MTUS

Guidelines state that a satisfactory response to opioid medications is indicated by the documentation of the patient's decreased pain, increased level of function, or improved quality of life. The guidelines also state that documentation should address the "4 A's" for ongoing monitoring. The "4 A's" includes analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The medical records submitted for review have a general lack of documentation regarding ongoing assessment, including the "4 A's", as required by the guidelines. Additionally, in the patient's most recent note dated 08/12/2013, it states that the patient is to be weaned off the narcotic medications. As the detailed documentation required by guidelines was not provided and the documentation shows the patient was to be weaned off narcotic medications, the request for this medication is not supported. The request for Fentanyl patches is not medically necessary and appropriate.

Hydrocodone/APAP 10, 325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The patient's medications were noted to include fentanyl patches 12 mcg every 3 days and Norco 10/325 mg 1 every 4 hours as needed for pain. California MTUS Guidelines state that a satisfactory response to opioid medications is indicated by the documentation of the patient's decreased pain, increased level of function, or improved quality of life. The Guidelines also state that documentation should address the "4 A's" for ongoing monitoring. The "4 A's" includes analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The medical records submitted for review have a general lack of documentation regarding ongoing assessment, including the "4 A's", as required by the Guidelines. Additionally, in the patient's most recent note dated 08/12/2013, it states that the patient is to be weaned off the narcotic medications. As the detailed documentation required by Guidelines was not provided and the documentation shows the patient was to be weaned off narcotic meds, the request for this medication is not supported. The request for hydrocodone is not medically necessary and appropriate.