

<b>Case Number:</b>	CM13-0027195		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	06/27/2002
<b>Decision Date:</b>	02/11/2014	<b>UR Denial Date:</b>	08/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/20/2013

### 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 Illinois. 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 67-year-old male who reported an injury on 06/27/2002. The patient is diagnosed with lumbago and pain in the thoracic spine. The patient was seen by [REDACTED] on 10/16/2013. The patient reported 5/10 pain with medication with continuing lower back pain causing tingling in the left hand. The patient also reported poor sleep quality due to anxiety. Physical examination revealed analgesic gait, limited cervical range of motion, tenderness to palpation in the neck and scapular region, full range of motion with 5/5 strength in bilateral lower extremities, intact sensation. Treatment recommendations included continuation of current medication and a follow-up with a help referral.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HELP program interdisciplinary evaluation, includes examination, physical therapy evaluation, and psychological assessment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration programs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration programs Page(s): 30-33.

**Decision rationale:** California MTUS Guidelines state functional restoration programs are recommended where there is access to programs with proven successful outcomes for patients with conditions that put them at risk of delayed recovery. An adequate and thorough evaluation should be made, including baseline functional testing. There should be evidence that previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement. There should also be evidence of a significant loss of ability to function independently resulting from the chronic pain. Patients should exhibit motivation to change and willingness to forego secondary gains. Negative predictors of success should be addressed. Total treatment duration should not generally exceed 20 full day sessions. There is no evidence of a failure to respond to previous methods of treating chronic pain. There is also no evidence of an absence of other options that are likely to result in significant clinical improvement. There is no indication that this patient is not a surgical candidate. The patient's physical examination only revealed tenderness to palpation and limited cervical range of motion. The patient demonstrated 5/5 motor strength with full range of motion of bilateral upper and lower extremities. The medical necessity for the requested service has not been established. Therefore, the request is non-certified.

**Fentanyl 50mcg/hour Q3 days #10/30 day supply:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl transdermal (Duragesic)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Fentanyl transdermal (Duragesic), Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report 5/10 pain with poor sleep quality. It is also noted that the patient has noticed a decrease in memory ability which he feels is due to medications. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or overall improved quality of life. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.

**Oxycodone 10mg #60/15 day supply:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and

functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report 5/10 pain with poor sleep quality. It is also noted that the patient has noticed a decrease in memory ability which he feels is due to medications. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or overall improved quality of life. Therefore, ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.