

Case Number:	CM13-0046750		
Date Assigned:	12/27/2013	Date of Injury:	06/23/2009
Decision Date:	04/24/2014	UR Denial Date:	10/15/2013
Priority:	Standard	Application Received:	11/01/2013

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. The expert reviewer is Board Certified in Anesthesia, has a subspecialty in Acupuncture & Pain Medicine 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 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/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:

54y/o female injured worker with date of injury 6/23/09 with related low back pain. Pain starts in the low back and radiates down to the left buttocks and left lower extremity down to the left knee joint. Per 12/4/13 progress report, pain was described as continuous sharp and aching rated 7/10. MRI of the lumbar spine dated 5/14/12 revealed early signs of disc degeneration at the L4-L5 level, disc bulging, mild facet and ligamentous hypertrophy, focal disc protrusion at the midline that is wedge-shaped and indents the thecal sac, disc material extends about 3mm beyond the disc margin, there is also mild foraminal stenosis at this level. There is evidence of previous wide decompression at L3-L4 with internal fixation of the vertebral body using pedicle screws with interconnecting bars. There is no residual central canal stenosis. There is mild foraminal stenosis. There has been a partial decompression performed at the L2-L3 level involving the left side with evidence of previous laminotomy and resection of the ligamentum flavum on the left side. There is no residual spinal stenosis. The documentation does not indicate that she has received physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

FENTANYL PATCHES DOS 9/25/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78,91,93.

Decision rationale: Per MTUS CPMTG, fentanyl transdermal is indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. It is not recommended as a first-line therapy. Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding on-going management of opioids "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 nonadherent) drug related behaviors. These domains have been summarized as the '4 A's' (Analgesia, activities of daily living, adverse side effects, and any 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." Review of the available medical records reveal no documentation to support the medical necessity of fentanyl patches nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. Additionally, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Furthermore, efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing this concern in the records available for my review. The request is not medically necessary.