

Case Number:	CM14-0106514		
Date Assigned:	07/30/2014	Date of Injury:	08/18/1999
Decision Date:	08/29/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/09/2014

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 Physical Medicine and 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 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:

The injured worker is a male with an unknown date of birth who reported an injury on 08/18/1999. The injured worker's diagnoses were noted to be thoracic/lumbar/sacral neuritis/radiculitis; muscle spasms; lumbar/lumbosacral intervertebral disc degeneration; postlaminectomy syndrome, lumbar region; injury to lumbar plexus; injury to lumbar nerve root; and lumbago. The injured worker had an L5-S1 fusion in 1991; an L4-5 fusion in 1992; an L3-4 fusion in 2000; replaced hardware in 2001 and 2002; loose screws repair in 2001; anterior/posterior flat back syndrome repair in 2005; hardware replacement in 2007; and L2-3 fusion in 2010. This was the only information available for review. The request did not contain a clinical evaluation, or a rationale for the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lazanda 400ugm, #32.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines:Opioids for Chronic Pain; Opioids For Neuropathic Pain; Therapeutic Trail of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Page(s): page(s) 47. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Lazanda FDA Package Insert.

Decision rationale: The request for Lazanda 400ugm, #32 is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines state fentanyl is an opioid analgesic with a potency 80 times that of morphine. Fentanyl is available in a buccal tablet; this is not recommended for musculoskeletal pain. The request is for Lazanda, a fentanyl nasal spray. Because of the risk for misuse, abuse, addiction, and overdose, Lazanda is available only through a restricted program required by the Food and Drug Administration called a risk evaluation and mitigation strategy. The documentation submitted for review fails to provide a clinical evaluation. Diagnoses and prior surgery information was noted on a previous review. According to the Lazanda FDA package insert, this medication carries high risk factors. Lazanda is not addressed by the MTUS Chronic Pain Medical Treatment Guidelines. The provider's request for Lazanda fails to provide a drug frequency. As such, the request for Lazanda 400ugm, #32 is non-certified.