

Case Number:	CM14-0165872		
Date Assigned:	10/10/2014	Date of Injury:	04/22/2002
Decision Date:	11/18/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/08/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey 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 patient is a 58-year-old man who sustained a work-related injury on April 22, 2002. The subsequently he developed with chronic back pain for which he underwent the lumbar decompression without significant improvement of his pain. The patient was diagnosed with faded lumbar back surgery and from, recurrent myofascial pain and bilateral lower extremity radiculopathy. His CT scan of the lumbar spine performed on April 11, 2014 demonstrated diffuse disc bulging from L2-L5, multilevel facet hypertrophy and foraminal stenosis According to a progress report dated on July 30 14, the patient was treated with pain medications including Duragesic patch, Percocet and Lortab. She was diagnosed with the insomnia, elected dysfunction anxiety and depression and was treated with the Viagra, Ambien, Zanaflex, Prilosec and non-steroid anti-inflammatory drugs. The provider request authorization to use Duragesic.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic 12mcg #10 no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid therapy. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 68.

Decision rationale: Duragesic fentanyl trans-dermal system, not recommended as a first-line therapy. Duragesic is the trade name of a fentanyl trans-dermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin. It is manufactured by [REDACTED] and marketed by [REDACTED] (both subsidiaries of [REDACTED]). The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The patient continued to have pain despite the previous use of Fentanyl and other opioids. The patient was prescribed Duragesic without clear and objective documentation of function improvement. There is no recent documentation of tolerance to opioids. There is no documentation that the patient condition required around the clock opioid therapy. Therefore the prescription of Duragesic 12mcg #10 with no refills is not medically necessary.