

<b>Case Number:</b>	CM14-0053420		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	04/08/2012
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	04/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 34-year-old female who reported an injury on 04/08/2012. The mechanism of injury was not provided within the medical records. The clinical note dated 05/21/2014 indicated diagnoses of lumbar degenerative disc disease, lumbar radiculopathy, sacroiliitis, patellofemoral syndrome, knee osteoarthritis on the left, right shoulder osteoarthritis, right shoulder rotator cuff syndrome, myofascial spasm, a history of gastric bypass and functional status in decline. The injured worker reported low back, shoulder and knee pain. The injured worker reported that she was using heat and ice to the low back, shoulder and knee. The injured worker declined a lumbar fusion. The injured worker reported that her activities were limited due to pain. The injured worker denied having any adverse effects from her medications. She also reported that her medications helped, but she was still in significant pain. On physical examination, there was tenderness to palpation to the left knee and tenderness to palpation to the right shoulder. The injured worker walked with an antalgic gait. There was tenderness to palpation to the lower back and pain with flexion and extension. The injured worker reported that she was able to sit, stand and walk for 10 minutes. The injured worker's prior treatments included diagnostic imaging, surgery, physical therapy and medication management. The injured worker's medication regimen included Fentanyl, Percocet and Gabapentin. The provider submitted a request for an ITMS trial, Fentanyl and Percocet. A Request for Authorization was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ITMS Trial:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations, IDDS (intrathecal drug delivery systems) and SCS (spinal cord stimulators) Page(s): 101.

**Decision rationale:** The California MTUS Guidelines recommend psychological evaluation for pre-intrathecal drug delivery systems (IDDS) and spinal cord stimulator (SCS) trial. The documentation submitted did not indicate that the injured worker had a psychological evaluation for an ITMS. In addition, the provider did not indicate a rationale for the request. Therefore, the request is not medically necessary.

**Fentanyl 50mcg #10:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 87.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl), On-going Management, Opioid Dosing Page(s): 44, 78, 86.

**Decision rationale:** The California MTUS Guidelines indicate that Duragesic (Fentanyl) is not recommended as a first-line therapy. 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. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status and evaluation of risk for aberrant drug use behaviors and side effects. In addition, the clinical note indicated that the injured worker was receiving 75 mg of Fentanyl. However, the request indicates 50 mcg of Fentanyl. Clarification is needed. In addition, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

**Percocet 10/325mg #150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 87.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-going Management Page(s): 78.

**Decision rationale:** The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status and evaluation of risk for aberrant drug use behaviors and side effects. In

addition, the injured worker reported that the medication helped, but she reported that she was still in significant pain. Moreover, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.