

<b>Case Number:</b>	CM14-0077672		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	06/12/1995
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	05/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2014

### 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 Nevada. 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 records presented for review indicate that this 64 year-old female injured worker was reportedly injured on 06/12/1995. The mechanism of injury is noted as a low back injury while pushing a gurney. The most recent progress notes dated 04/25/2014, 05/23/2014 and 06/16/2014, indicate that there are ongoing complaints of chronic low back pain. No recent physical examination is documented. No recent diagnostic imaging studies are available for review. Pain level was documented 4/10 on the visual analog scale in the office from April to June 2014. Diagnoses include chronic low back pain, degenerative lumbar spondylosis, myofascial pain syndrome, depression and insomnia. Previous treatments includes medications, Fentanyl patches 15, Tramadol 50mg, Ibuprofen 800mg, Percocet 10/325mg and Tylenol #4. A request had been made for Fentanyl 25mg #30, Fentanyl 50mg #30, Tramadol 50mg #180 and Percocet 10/325mg #60, in the utilization review on 05/07/2014. A partial certification was granted for Fentanyl 25mg #20, Fentanyl 50mg #20, Tramadol 50mg #120 and Percocet 10/325mg #40.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fentanyl 25mg quantity #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 93.

**Decision rationale:** The MTUS guidelines support long-acting opiates in the management of chronic pain when continuous around the clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Treatment guidelines specifically state Fentanyl is not recommended for musculoskeletal pain. Review of the available medical records, fail to document improvement in pain or function with the current treatment regimen. Given the date of injury, clinical presentation and current diagnosis, this request is not considered medically necessary.

**Fentanyl 50mg quantity #10:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 93.

**Decision rationale:** The MTUS guidelines support long-acting opiates in the management of chronic pain when continuous around the clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Treatment guidelines specifically state Fentanyl is not recommended for musculoskeletal pain. Review of the available medical records, fail to document improvement in pain or function with the current treatment regimen. Given the date of injury, clinical presentation and current diagnosis, this request is not considered medically necessary.

**Tramadol 50mg quantity #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113.

**Decision rationale:** The MTUS guidelines support the use of Tramadol (Ultram) for short-term use after there has been evidence of failure of a first-line option, evidence of moderate to severe pain and documentation of improvement in function with the medication. A review of the available medical records, fails to document any improvement in function or pain level with the previous use of Tramadol. Furthermore, the claimant is being given three short acting opioid analgesics to include Percocet, Tramadol and Tylenol #4. As such, the request is not considered medically necessary.

**Percocet 10/325mg quantity #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75.

**Decision rationale:** The MTUS guidelines support the use of Percocet for intermittent or breakthrough, moderate to severe pain. A review of the available medical records, fails to document any improvement in function or pain with the previous use of Percocet. Furthermore, the claimant is being given three short acting opioid analgesics to include Percocet, Tramadol and Tylenol #4. As such, the request is not considered medically necessary.