

Case Number:	CM14-0134798		
Date Assigned:	08/29/2014	Date of Injury:	06/14/2005
Decision Date:	01/31/2015	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	08/22/2014

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 Physical Medicine Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 66-year-old female with a date of injury of 06/14/2005. The listed diagnoses are: 1. Cervical spondylosis. 2. Rotator cuff tear. The mechanism of injury occurred when the patient was involved in a motor vehicle accident. The treating physician has provided 8 handwritten (grossly illegible) duplicate progress reports with verbatim findings, but with different dates. It was noted the patient has an increase in pain and positive tenderness in the shoulder. There is an "industrial patient status report" dated 02/06/2014, which noted the patient is status post rotator cuff tear on the right. The patient's pain was rated as 7/10 on a scale of 1 to 10. It was noted the patient presents for a follow-up and medication refills. The patient is permanently disabled. Recommendation was for a referral to (illegible). The current request is for fentanyl DIS 75 mcg/hr #15 and hydrocodone/APAP tablet 10/325 mg #120. The utilization review denied the request on 08/05/2014. Treatment reports from 02/06/2014 through 08/25/2014 were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl Dis 75mcg/Hr #15 (30 Days Supply): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids Page(s): 88-89, 78.

Decision rationale: This patient presents with neck and rotator cuff tear on the right. The current request is for Fentanyl DIS 75 mcg/hr #15 (30-day supply). The MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, activities of daily livings ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. On 02/06/2014, the patient presented for refill of medications. It appears the patient has been utilizing this medication prior to then as this is a request for refill. In this case, recommendation for further use cannot be supported as the treating physician has provided no discussion regarding functional improvement or changes in ADL as required by MTUS for opiate management. There is no before and after pain scale to show analgesia and possible aberrant behaviors and adverse side effects have not been addressed. The treating physician has failed to document the minimum requirements of documentation that are outlined in the MTUS for continued opiate usage. Therefore, this request is not medically necessary.

Hydrocodone/APAP tab 10-325mg #120 (30 days supply): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids Page(s): 88-89, 78.

Decision rationale: This patient presents with neck and rotator cuff tear in the right. The current request is for hydrocodone/APAP tablet 10/325 mg #120 (30-day supply). The MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, activities of daily livings (ADLs), adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. On 02/06/2014, the patient presented for refill of medications. It appears the patient has been utilizing this medication prior to then and the request was for a refill. In this case, recommendation for further use cannot be supported as the treating physician has provided no discussion regarding functional improvement or changes in ADL as required by MTUS for opiate management. There is no before and after pain scale to show analgesia and possible aberrant behaviors and adverse side effects have not been addressed. The treating physician has failed to document the minimum requirements of documentation that are outlined in the MTUS for continued opiate usage. Therefore, this request is not medically necessary.

