

<b>Case Number:</b>	CM14-0184242		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	04/17/2001
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	10/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2014

### 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 Occupational Medicine 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:

This patient is a 52 year-old female with date of injury 04/17/2001. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 09/30/2014, lists subjective complaints as pain in the low back with radicular symptoms down the left lower extremity. Objective findings: Examination of the lumbar spine revealed tenderness to palpation of the paravertebral muscles. Range of motion was restricted in flexion and extension. Motor examination of the lower left extremity revealed left EHL weakness, graded 4/5. Sensory examination revealed decreased sensation to light touch in the left big toe. Diagnosis: 1. Lumbosacral spondylosis 2. Post-laminectomy syndrome, lumbar. The medical records supplied for review document that the patient has been taking the following medication for at least as far back as six months. Medications: 1. Fentanyl DIS 25mcg/hr, #15 SIG: one every 4-6 hours

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fentanyl dis 25 mcg/hr 30 day supply # 15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Page(s): 74-94.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little functional improvement over the course of the last 6 months. Fentanyl dis 25 mcg/hr 30 day supply # 15 is not medically necessary.