

Case Number:	CM15-0002746		
Date Assigned:	01/13/2015	Date of Injury:	04/12/2001
Decision Date:	04/10/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/06/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 65-year-old female who reported an injury on 04/12/2001. The mechanism of injury involved a fall. The current diagnoses include chronic pain syndrome, cervical spondylosis without myelopathy, degeneration of cervical intervertebral disc, headache, lumbosacral spondylosis without myelopathy, degeneration of lumbar or lumbosacral intervertebral disc, and depressive disorder. The injured worker presented on 12/15/2014 for a follow-up evaluation with complaints of bilateral low back pain with radiation into the right lower extremity as well as neck pain. Previous conservative treatment was noted to include physical therapy, TENS therapy, cervical epidural steroid injections, and medication management. The current medication regimen includes Norco 10/325 mg, fentanyl patch, Cymbalta 60 mg, Carafate 1 gm, Wellbutrin 300 mg, Prozac 20 mg, and Imitrex. There was positive straight leg raise bilaterally, worse on the right, as well as lumbar facet tenderness. There was diminished range of motion of the cervical spine with tenderness to palpation. There was slightly restricted lumbar range of motion. There was decreased sensation in the bilateral lower extremities. Recommendations at that time included continuation of the current medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl patch 12mcg #10 + 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Page(s): 78; 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 74-82.

Decision rationale: The California MTUS Guidelines do not recommend fentanyl transdermal patch as a first line therapy. It has been FDA approved in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. There was no documentation of a failure of first line therapy prior to the initiation of fentanyl transdermal patch. It was also noted that the injured worker has continuously utilized the medication since at least 06/2014. There was no documentation of objective functional improvement. Given the above, the request is not medically appropriate.

Norco 10/325mg #60 + 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Opioids Page(s): 78, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized the above medications since at least 06/2014. There was no documentation of objective functional improvement. There was also no frequency listed in the request. Given the above, the request is not medically appropriate.