

Case Number:	CM15-0164898		
Date Assigned:	09/02/2015	Date of Injury:	07/21/1998
Decision Date:	10/14/2015	UR Denial Date:	07/24/2015
Priority:	Standard	Application Received:	08/21/2015

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: Massachusetts

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 sustained an injury on 7-21-98. She has chronic low back pain and was being followed by pain management for constant back pain and right buttock pain. Diagnosis is status post L3-4 laminotomy decompression on 9-23-14. As noted on 3-9-15 she was complaining of severe and constant low back and right buttock pain. She stopped taking Dilaudid and went back to Fentanyl patch 50 mcg and found it be effective. The medical records (6-22-15) indicate she had a second SI injection and there has not been further improvement. She has been using the Fentanyl 50 mcg but that her pain is rated still very high, 8- 10 out of 10 and is not able to get out of the house some days due to the pain. On 7-20-15 she reports persistent pain in her back that is rated severe and radiates into her bilateral lower extremities. She is scheduled for an epidural steroid injection. The records indicate that her dose of Fentanyl was increased from 50 to 75 mcg and that she has some improvement with the increased dosage. She is able to sit for longer (increased from 5 to 25-30 minutes); stand longer (from 5 to 10-15 minutes) and is able to participate more with friends and family. Physical examination reveals gait is antalgic; range of motion is limited; severe pain with moderate restriction on flexion; extension moderate restriction and lateral bending is moderate restriction. The plan is to proceed with caudal ESI; continue with current medications; random urine drug screen (June 2015 was reviewed and appears appropriate). Medications include Fentanyl 50 mcg; 1 patch every 72 hours; Flexeril 10 mg 1 three times a day. Current requested treatments Fentanyl 75 mcg #10. Utilization review 7-24-15 requested treatment is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 75 mcg #10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, dosing.

Decision rationale: The claimant has a remote history of a work injury occurring in July 1998 and continues to be treated for low back, left leg, and left knee pain. In March 2015, she stopped taking Dilaudid and had restarted fentanyl from an old prescription and found that it was effective. When seen, there was a pending epidural injection. She had recently undergone left knee Synvisc injections but was having increasing pain, swelling, and stiffness. A left total knee replacement was being planned. Her fentanyl dose had been increased at the previous visit with improvement in some of her pain. Her pain had decreased from 9+10 to 6/10 with longer sitting and standing tolerances. Physical examination findings included decreased and painful lumbar range of motion and extensive pain with lumbar palpation. There was decreased knee range of motion. Medications were continued. Fentanyl was being requested at a total MED (morphine equivalent dose) of 180 mg per day. Guidelines recommend against opioid dosing is in excess of 120 mg oral morphine equivalents per day. In this case, the total MED being prescribed is 1.5 times that recommended. The claimant is expected to have somewhat predictable activity related breakthrough pain (i.e. incident pain) when standing and walking due to her knee osteoarthritis and there is no immediate release medication being prescribed for breakthrough pain. Additionally, if she has developed tolerance, opioid rotation could be considered. Although the claimant has chronic pain and the continued use of opioid medication may be appropriate, there are no unique features of this case that would support dosing at this level. Ongoing prescribing at this dose was not medically necessary.