

<b>Case Number:</b>	CM15-0195108		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	06/30/1997
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 51 year old female, who sustained an industrial-work injury on 6-30-97. She reported initial complaints of neck and back pain. The injured worker was diagnosed as having chronic low back pain, lumbar laminectomy and fusion with removal of hardware, lumbar radiculopathy, chronic intermittent neck pain, cervicogenic post traumatic migraines- tension mixed headaches, depression and anxiety. Treatment to date has included medication, diagnostics, psychotherapy sessions, and surgery. Currently, the injured worker complains of constant burning lower back pain radiating down the left buttock, lateral left leg, and bottom and top of the left foot. It was aggravated by sneezing, coughing, walking, bending, sitting, standing, and lifting with decrease function since last analgesic taper. Pain was rated 5 out of 10. There was also pain to the neck, spasms, and headaches down to shoulders, diffuse upper extremity weakness and right hand numbness and rated 9 out of 10. Meds were Fentanyl patch, Dilaudid, Clonazepam, Geodon, Lexapro, and Lunesta. Drug testing was consistent with what was prescribed. Per the primary physician's progress report (PR-2) on 9-15-15, exam noted stable mood, slow antalgic gait requiring a single point cane, moderate cervical paraspinal tenderness and upper trapezius tenderness, limited range of motion, weakened grip strength, diminished sensation to upper extremities. Lumbar spine had severe tenderness to the paraspinals, 4 out of 5 strength to the lower extremities, diminished sensation to the lateral aspect of the left leg and medial aspect of the left lower leg, positive straight leg raise on the left more than the right. Current plan of care includes renew medication adjustment, continue psychological treatment, and follow up. The Request for Authorization requested service to include Fentanyl patch 50mcg#15. The Utilization Review on 9-24-15 modified the request for Fentanyl patch 50mcg #10 , per CA MTUS (California Medical Treatment Utilization Schedule), Chronic Pain Medical Treatment Guidelines 2009.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Fentanyl patch 50mcg #15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Duragesic (fentanyl transdermal system).

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

**Decision rationale:** The patient presents with pain affecting the low back with radiation down the left lower extremity, and the neck with radiation to the bilateral shoulders. The current request is for Fentanyl Patch 50mcg #15. The treating physician report dated 9/15/15 (67B) states, "She complains of decreased function since tapering down on medications. Her pain can escalate to 15/10 on the VAS." MTUS pages 88 and 89 states "document pain and functional improvement and compare to baseline, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS also requires documentation of the four A's (analgesia, ADL's, Adverse effects and Adverse behavior). The medical reports provided show the patient has been using a Fentanyl patch since at least 3/3/15 (46B). The report dated 9/15/15 (67B) notes that the patient's current pain level is 9/10. No adverse effects or adverse behavior were noted by patient. The patient's ADL's have not improved since she was weaned from 100mcg Fentanyl patches to 50mcg. The patient's last urine drug screen was consistent and the physician has a signed pain agreement and CURES report on file as well. The continued use of a Fentanyl patch has not improved the patient's symptoms and has not provided that patient with any documented functional improvements. In this case, the patient presents with a decrease in function and a current pain level of 9/10. The most current medical report provided for review provided no documentation of functional improvement. The current request is not medically necessary.