

<b>Case Number:</b>	CM15-0220219		
<b>Date Assigned:</b>	11/13/2015	<b>Date of Injury:</b>	01/09/2003
<b>Decision Date:</b>	12/22/2015	<b>UR Denial Date:</b>	10/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/09/2015

### 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: New York, Pennsylvania, Washington  
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

### 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 (IW) is a 52 year old male, who sustained an industrial injury on 1-09-2003. The injured worker is being treated for other intervertebral disc degeneration lumbosacral region, cervicalgia, post laminectomy syndrome and other long term drug therapy. Treatment to date has included surgical intervention (L4-S1 fusion, 2004, revision, 2006 and C4-7 fusion, 2007), psychiatric evaluation and treatment, physical therapy, chiropractic, epidural injections, acupuncture, medications, massage, ice and heat application, and diagnostics. Per the Initial Comprehensive Pain Management Evaluation dated 10-20-2015, the injured worker reported chronic neck, thoracic, lumbar and right shoulder from torn rotator cuff and bilateral hip left greater than right pain with associated numbness and tingling. He wants to be off meds but notes the pain was severe and it decreased his functioning. He may need pain meds if it truly helps with pain and functioning. The pain is decreased with medications including Fentanyl patch he hasn't been on patch for several weeks. He's been on Norco lately along with neurontin. He's been in bed most of the day. He's been wondering about IT pump option and has had some issues with cops regarding his license. He reports foot drop and bladder and bowel dysfunction, There is crunching, grinding and popping in the back. Objective findings included decreased ranges of motion of the lumbar spine with paralumbar muscle spasms. Cervical spine exam revealed trigger points and tenderness with myofascial pain. Range of motion of the right shoulder was decreased with pain when touching hands over head. There is no documentation of functional improvement in symptoms, increase in activities of daily living or decrease in pain level with the current treatment. The plan of care included a retrial of Fentanyl patch, retrial of

Norco, trial of Lyrica, and IT trial. The IW has utilized Norco and Fentanyl patch in the past but it is unclear from the medical records provided how long he has been taking them. Authorization was requested for Fentanyl patch 50 ugm #10, Norco 10-325mg #90, Lyrica 100mg #90, psych eval for clearance IT pain pump trial and IT pump trial. On 10-28-2015, Utilization Review non-certified the request for Fentanyl patch 50 ugm #10, psych eval for clearance IT pain pump trial and IT pump trial and modified the request for Norco 10-325mg #90.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Fentanyl patch 50 ugm #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): Fentanyl, Opioids for chronic pain.

**Decision rationale:** Per the guidelines, in opioid use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The [REDACTED] visit fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to opioids to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The request is not medically necessary or substantiated in the records.

#### **Psych evaluation for clearance for IT pain pump trial: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Stress-Related Conditions 2004, Section(s): Treatment, Follow-up.

**Decision rationale:** Specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities. It is recognized that primary care physicians and other non-psychological specialists commonly deal with and try to treat psychiatric conditions. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist, while common psychiatric conditions, such as mild depression, be referred to a specialist after symptoms continue for more than six to eight weeks. Patients with more serious conditions may need a referral to a psychiatrist for medicine therapy. This injured worker does not have a documented psychiatric illness. The primary care physician can treat the symptoms first prior to referral to a psychologist or psychiatrist. The records do not substantiate the medical necessity for referral to a psychiatrist. The request is not medically necessary.

**IT pump trial:** 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): Implantable drug-delivery systems (IDDSs).

**Decision rationale:** Implantable drug delivery systems are only recommended as an end-stage treatment alternative for selected patients for specific conditions indicated below, after failure of at least 6 months of less invasive methods, and following a successful temporary trial. Results of studies of opioids for musculoskeletal conditions (as opposed to cancer pain) generally recommend short use of opioids for severe cases, not to exceed 2 weeks, and do not support chronic use (for which a pump would be used), although IDDSs may be appropriate in selected cases of chronic, severe low back pain or failed back syndrome. This treatment should only be used relatively late in the treatment continuum, when there is little hope for effective management of chronic intractable pain from other therapies. This injured worker does not meet these criteria to medically substantiate an IT pump trial. The request is not medically necessary.