

Case Number:	CM14-0121173		
Date Assigned:	09/16/2014	Date of Injury:	09/24/2003
Decision Date:	10/24/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/31/2014

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 Family 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:

The injured worker is a 62 year old female injured on 09/24/03 due to an undisclosed mechanism of injury. Neither the specific injuries sustained nor the initial treatments rendered were discussed in the documentation provided. Impression included status post TLIF for disc injury with degenerative spondylolisthesis and instability at L4, left sided overgrowth from BMP, status post revision laminectomy with partial hardware removal and decompression, rule out junctional change at L3-4, and right knee anterior meniscal injury. QME performed on 08/21/14 indicated the injured worker presented complaining of constant low back pain radiating into the mid-back and bilateral lower extremities with associated burning, numbness, and tingling into the legs and feet. The documentation also indicated the injured worker underwent spinal cord stimulator placement on an undisclosed date. Physical examination revealed lower lumbar and sacral notch muscle tenderness positive, decreased lumbar range of motion, abnormal minimal anterior joint tenderness without swelling or effusion at the right knee, sensation intact to the bilateral upper and lower extremities, deep tendon reflexes 2+ to the bilateral lower extremities, motor strength 5/5 bilaterally. Medications included Zanaflex, Lyrica, Fentanyl 75mg, and Dilaudid. No other documentation was provided for review. The initial request was non-certified on 07/03/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic 75 mcg #10 1 topically every 72 hours: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid therapy: Fentanyl transdermal (Duragesic). Decision based on Non-MTUS Citation Bohnert, 2011; Washington, 2002

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As such, Duragesic 75 mcg #10 1 topically every 72 hours is not medically necessary at this time.