

<b>Case Number:</b>	CM14-0131781		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	03/31/2007
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	08/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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 Physical Medicine & Rehabilitation, Pain Medicine and is licensed to practice in California and Washington. 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 42-year-old female who reported injury on 03/31/2007 caused by an unspecified mechanism. The treatment history included EMG/NCS studies, physical therapy, medications, MRI studies, and psychological evaluation. The injured worker was evaluated on 08/04/2014 and it was documented the injured worker complained of neck pain and right shoulder pain. The injured worker's neck pain radiated into both arms right greater than left, 8/10 severity, constant, burning, throbbing, aching, and increased with activity. The pain was relieved with medications, moist, heat, and H-wave. Physical examination of the right shoulder there was tenderness and reduced range of motion. Diagnoses included cervical radiculopathy, cervical spinal stenosis, cervical degenerative disc disease, cervical facet joint arthropathy, neck pain, status post surgery, chronic pain syndrome, opiate dependence, insomnia, and nausea and vomiting due to medication which she takes to relieve her work related pain. Medications included Lidoderm patches, Cymbalta, Robaxin, Topamax, trazodone, and Ultracin lotion. The Request for Authorization dated 08/04/2014 was for fentanyl 50 mcg patches and Percocet 10/325 mg. The rationale for medications was to relieve injured worker's pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fentanyl 50mcg #15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl Transdermal System) & Fentanyl Page(s): 44& 47.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) guidelines do not recommend Duragesic fentanyl transdermal system as a first-line therapy. Duragesic is the trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin. The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. Fentanyl is an opioid analgesic with a potency eighty times that of morphine. Weaker opioids are less likely to produce adverse effects than stronger opioids such as fentanyl. The documents submitted for review lacked evidence of conservative care outcome measures of physical therapy and home exercise regimen for the injured worker. In addition, the request failed to indicate location where the Fentanyl patch should be applied on the injured worker. Therefore, the request for fentanyl 50mcg # 15 is not medically necessary and appropriate.

**Perocet 10/325mg #240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity of pain relief for the injured worker. There was lack of documentation of long-term functional improvement goals for the injured worker. In addition, the request does not include the frequency or duration. Given the above, the request for Percocet 10/325 mg # 240 is not medically necessary.