MAXIMUS Federal Services

Case Number:	CM14-0099100		
Date Assigned:	09/16/2014	Date of Injury:	04/02/2009
Decision Date:	10/21/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/27/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 53-year-old female who reported an injury on 04/02/2009. Reportedly the injured worker sustained injuries to her shoulder when a student threw a chair in the walkway causing her to trip and fall. The injured worker's treatment history included MRI studies, medications, epidural steroid injections, massage therapy, and drug screen. The injured worker had a urine drug screen on 11/25/2013 that was positive for opiate usage. The injured worker was evaluated on 06/13/2014. It was documented the injured worker complained of right arm, neck, and back pain. Her pain was characterized as sharp, throbbing, burning, and electricity. The injured worker's pain was constant. Her pain was increased by sitting, walking, standing, and movement. She indicated that her pain was decreased by lying down and medication. Physical examination revealed severely decreased range of motion with left side turning, more restricted than right side turning. Pain in the right 4th and 5th fingers was exacerbated by neck extension. Her first 3 fingers are continuously numb. Radicular pain was also increased by pronation and supination of the hand causing weakness in her grip strength. She had decreased DTR at the right biceps. The injured worker was right hand dominant and her left UE was paralyzed so the pain with use of the right hand was severely limited. The injured worker was wearing a left ankle brace and ambulated with a cane. The injured worker had limited range of motion of the right arm with swelling and tenderness at the ulnar aspect of her right wrist. She had TTP at the medial and lateral epicondyle of the elbow. She had pain with pronation and supination. Medications included Fentanyl transdermal system and Ultracin. Diagnoses included spinal stenosis, cervical spondylosis, brachial neuritis, and opiate type dependency. The Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 12 mcg/hr PR #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (Page(s): 78.

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

Decision rationale: The requested is not medically necessary. 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 pain medication management and home exercise regimen for the injured worker. In addition, the request failed to indicate location where the Fentanyl patch should applied on the injured worker. The request failed to indicate duration and frequency of medication. The medical records submitted for review identified ongoing complaints of chronic pain that have been unresponsive to most all treatment interventions, with chronic use of opiates and a request for continued support of fentanyl patches in combination with Vicodin HP. As such, the request for fentanyl 12 mcg/hr. PR #10 is not medically necessary.

Vicodin HP 10mg/300mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The requested is not medically necessary. 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. The provider failed to submit urine drug screen indicating opioids compliance for the injured worker. There was no outcome measurements indicated for the injured worker such as physical therapy or home exercise regimen for the injured worker. There was lack of documentation of long-term functional improvement for the injured worker. In addition, the request does not include the frequency or duration of medication. Given the above, the request for Vicodin HP 10 mg/300 mg #180 is not medically necessary.