

Case Number:	CM15-0069266		
Date Assigned:	04/16/2015	Date of Injury:	06/30/1997
Decision Date:	05/18/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	04/13/2015

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 is a 51 year old female, who sustained an industrial injury on 6/30/1997. She reported initial complaints of back injury. 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; anxiety; bipolar disorder. Treatment to date has included lumbar fusion L3-4 and L5-S1 (11/97); spinal cord stimulator trial (1997); lumbar spine MRI (3/24/14); psychiatric care; pain management; medications. Currently, the PR-2 notes dated 2/3/15 indicated the injured worker returns to the clinic for follow-up and reevaluation last seen on 1/6/15. The injured worker's most recent urine drug screening was 7/23/14 and consistent with prescribed medicates. She continues to experience constant burning low back pain with radiation down the left buttocks, lateral left leg, and the bottom and top of left foot. She also feels burning pain in her heels, which is worse at night with occasional radicular pain down the right leg with numbness to the toes and bottom of right foot. Her low back pain is aggravated by sneezing, coughing, walking, bending, sitting, standing and lifting. The injured worker also complains of worsening, intermittent neck and upper back pain with radiation down both shoulders and occasional weakness in her upper extremities diffusely, associated with numbness in the right hand and headaches. She rates the pain as 6/10. The provider requested one prescription of Fentanyl 75mcg, #15 and one prescription of Fentanyl 12mcg, #15 and both were modified at Utilization Review to #10 per request for weaning.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Fentanyl 75mcg, #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-80.

Decision rationale: This injured worker has chronic pain with an injury sustained in 1997. The medical course has included numerous treatment modalities including surgery and use of several medications including narcotics. 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 MD visit of 3/15 fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to fentanyl to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of fentanyl is not substantiated in the records. The request is not medically necessary.

One prescription of Fentanyl 12mcg, #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-80.

Decision rationale: This injured worker has chronic pain with an injury sustained in 1997. The medical course has included numerous treatment modalities including surgery and use of several medications including narcotics. 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 MD visit of 3/15 fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to fentanyl to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of fentanyl is not substantiated in the records. The request is not medically necessary.