

Case Number:	CM15-0072427		
Date Assigned:	04/27/2015	Date of Injury:	04/20/1987
Decision Date:	05/27/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	04/16/2015

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: California, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 63 year old male who sustained an industrial injury on 4/20/87. The injured worker reported symptoms in the back. The injured worker was diagnosed as having low back pain, backache unspecified, radiculopathy thoracic or lumbosacral chronic, failed back surgery syndrome lumbar chronic, lumbar degenerative disc disease chronic, facet joint degeneration and lumbar spondylosis without myelopathy. Treatments to date have included heat/ice, massage, rest, and oral pain medication. Currently, the injured worker complains of lower back pain with radiation to the lower extremities. The plan of care was for medication prescriptions. A prior utilization review on 2/12/15 allowed for a smaller amount to be given for the Fentanyl due to lack of documentation required by guidelines to support the high dose of Fentanyl on such a short day change interval and #20 was allowed for better documentation of the need for such a high daily dose of opioids.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl Dis 75mcg/hr day supply Supply: 30 Qty: 30 Refills: 0 Rx date 4/9/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Page(s): 44, 47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Duragesic (fentanyl) #30, California Pain Medical Treatment Guidelines state that fentanyl is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Regarding the use of Fentanyl, guidelines state that it should be reserved for use as a second-line opiate. Within the documentation available for review, there is indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), and documentation regarding side effects, and discussion regarding aberrant use. Furthermore, there is mention of failure of first-line opiate therapy. However, it is also recommend that dosing not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. As such, there is no clear indication for ongoing use of the medication at the current level. Opioids should not be abruptly discontinued, but fortunately, a prior utilization review allowed for a lesser amount to be given. In light of the above issues, the currently requested Duragesic (fentanyl) #30 is not medically necessary.

Hydrocod/Ibu tab 7.5-200 day supply: 30 Qty: 150 Refills: 0 (Rx Date 4/9/2015):
Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Vicoprofen (hydorcodone/ibuprofen), California Pain Medical Treatment Guidelines state that Vicoprofen is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), and documentation regarding side effects, and discussion regarding aberrant use. As such, there is clear indication for ongoing use of the medication. In light of the above issues, the currently requested Vicoprofen (hydorcodone/ibuprofen) is medically necessary.