

Case Number:	CM13-0018270		
Date Assigned:	10/11/2013	Date of Injury:	05/27/2003
Decision Date:	01/21/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	08/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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.

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 patient is a 52-year-old female with a reported date of injury on 05/27/2003. The patient presented with cervical spine pain, upper extremity pain bilaterally, limited range of motion, radicular symptoms, reduced grip strength, allodynia, tenderness in the occiput, headache symptoms that were becoming more constant, 4/5 cervical flexion and extension strength, severe spasming of the paracervical muscles, right shoulder pain with decreased range of motion, and pain to the upper back. The patient denied nausea, vomiting due to pain, diarrhea, constipation, and dizziness. The patient had diagnoses including CRPS I to the right upper extremity, right shoulder pain status post arthroscopic RCR revision, scope, subacromial decompression, poor sleep hygiene, cervicgia with right sided radiculopathy, cervicgia with symptoms of cervical spondylosis and cervicogenic headache, myofascial pain/spasm, and status post spinal cord stimulator implant. The physician's treatment plan included a request for Celebrex 200 mg #60 with 1 refill, methadone 10 mg #90, and Percocet 10/325 mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 67-68.

Decision rationale: The California MTUS guidelines recommend the use of NSAIDs for patients with osteoarthritis (including knee and hip) and patients with acute exacerbations of chronic low back pain. The guidelines recommended NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. In patients with acute exacerbations of chronic low back pain, the guidelines recommend NSAIDs as an option for short-term symptomatic relief. The guidelines also note, COX-2 inhibitors (e.g., Celebrex) may be considered if the patient has a risk of GI complications, but not for the majority of patients. Per the provided documentation, it appeared the patient had been utilizing the medication Celebrex since 01/2011. The guidelines recommend NSAIDs for short-term use for acute exacerbations of chronic low back pain. The guidelines also note COX-2 inhibitors may be considered in patients with a risk of GI complications, but not of the majority of patients. Within the provided documentation, it was unclear why the patient was utilizing a COX-2 inhibitor as opposed to NSAIDs not used for patients with risk of GI complications. Additionally, within the provided documentation, the requesting physician did not indicate whether the patient had objective functional improvement with the use of the medication. Therefore, the request for Celebrex 200 mg #60 with 1 refill is neither medically necessary nor appropriate.

Methadone 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61-62, 78.

Decision rationale: The California MTUS guidelines note Methadone is recommended as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk. The guidelines note the risks and benefits of the medication should be weighed and patients should be closely monitored, especially during treatment initiation and dose adjustments. The guidelines recommend patients utilizing opioid medication should obtain prescriptions from a single practitioner, medications should be taken as directed, and all prescriptions should come from a single pharmacy. Providers should prescribe the lowest possible dose should be prescribed to improve pain and function. Provider should conduct ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The provider noted the patient's average pain since the last visit was rated 9/10. Within the provided documentation, the requesting physician did not include adequate documentation of objective functional improvement with the use of the medication. Additionally, the requesting physician did not include an adequate and complete assessment of the patient's pain including current pain, the least reported pain over the period since the last assessment, intensity of the pain after taking

the opioid, how long it takes for pain relief, and how long pain relief lasts. Therefore, the request for methadone 10 mg #90 is neither medically necessary nor appropriate

Percocet 10/325mg #120: Upheld

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

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

Decision rationale: The California MTUS guidelines recommend patients utilizing opioid medication should obtain prescriptions from a single practitioner, medications should be taken as directed, and all prescriptions should come from a single pharmacy. Providers should prescribe the lowest possible dose should be prescribed to improve pain and function. Provider should conduct ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The provider noted the patient's average pain since the last visit was rated 9/10. Within the provided documentation, the requesting physician did not include adequate documentation of objective functional improvement with the use of the medication. Additionally, the requesting physician did not include an adequate and complete assessment of the patient's pain including current pain, the least reported pain over the period since the last assessment, intensity of the pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Therefore, the request for Percocet 10/325 #120 is neither medically necessary nor appropriate.