

<b>Case Number:</b>	CM14-0011293		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	03/02/2006
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	01/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2014

### 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 Management and is licensed to practice in Tennessee. 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:

This is a 66-year old female with a 3/2/06 date of injury. Her diagnosis is failed back syndrome, bilateral Sacroiliac joint (SI) pain, and right shoulder impingement syndrome. The patient was seen on 12/20/13 complaining of low back pain and worsening low back pain over the last 3 weeks. Her Tizanidine has not been effective for this. A prior SI injection was noted to drop her pain from an 8/10 to a 1/10 in the hips for 6 months. Exam findings revealed a slow antalgic gait. There was decreased range of motion of the lumbar spine with pain, tenderness over the left SI joint, positive Faber's test on the left, and pain on movement of the left hip, as well as pain on movement of the right shoulder. Her medications include Tizanidine, Oxycontin 20 mg twice per day, Percocet 10/325 8 daily, Valium 5 mg three times per day. A UR decision dated on 1/15/14 the request for Percocet was modified from #240 to #210 given the patient was also noted to be on Oxycontin 20 mg twice per day, 210 tablets of Percocet were authorized in order to continue weaning, especially given the patient recently had an SI injection resulting in pain relief on VAS form 8/10 to a 1/10. Valium was modified from #90 to #60 given there was no rationale for ongoing use of this medication or documentation of significant benefit. The patient's primary physician wanted to initiate a taper in this patient with regard to this medication as discussed in the prior UR decision and this was the amount agreed upon.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PERCOCET 10/325MG #240:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opiates Page(s): 78-81.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The patient is on Oxycontin 20 mg by mouth, twice per day in addition to her Percocet. Her total medications are 180 with both medications. The patient's Oxycontin 20 mg twice per day was continued so that her Percocet could continue being weaned (210/240 tablets were authorized), especially given the patient recently had an SI injection resulting in pain relief on VAS form 8/10 to a 1/10. Therefore the request for #240 Percocet is not medically necessary.

**VALIUM 5MG #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that benzodiazepines range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. They are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. There is no rationale documented for the ongoing use of this medication with regard to this patient's spasm. Therefore, the request for Valium #90 is not medically necessary.