

Case Number:	CM14-0063368		
Date Assigned:	07/11/2014	Date of Injury:	03/02/2006
Decision Date:	09/12/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/06/2014

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 Texas. 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 66-year-old female injured on 03/02/06 due to an undisclosed mechanism of injury. Diagnoses include impingement of the right shoulder, failed back surgery syndrome, and bilateral sacroiliac joint pain. Clinical note dated 04/09/14 indicates the injured worker presented complaining of shoulder pain and discomfort after injection procedure. Documentation indicates the injured worker reported significant pain following shoulder injection and increased anxiety; however, symptoms had begun to subside and are really from injection approximately 75% with improved range of motion. The injured worker complained of low back, buttock, and hand pain unchanged from previous visits. The injured worker reported without medications and injection therapy she would be very limited. Examination revealed difficulty sitting comfortably, stiffness and pain when rising from chairs, axial tenderness of the lumbar spine on palpation, decreased range of motion, and significant tenderness to palpation over bilateral sacroiliac joints, pain with flexion and internal rotation of bilateral hips. Examination revealed sensation intact bilaterally to touch, lymphedema to bilateral lower extremity and erythematous, straight leg raise negative, motor strength 3/5, and sensory loss to bilateral lower extremities. Medications included Oxycontin 20mg twice a day, Percocet 10/325mg 1-2 tablets every 4-6 hours as needed, and Valium 5mg three times a day. The initial request for 1 prescription of Percocet 10/325mg #240 and Valium 5mg #90 was initially non-certified on 04/21/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Percocet 10/325mg #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet (R) (oxycodone & acetaminophen); Opioids, Criteria for use: When to Discontinue Opioids ... When to Continue Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of 1 prescription of Percocet 10/325mg #240 is not medically necessary.

1 prescription of Valium 5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines (Valium); Weaning of Benzodiazepines.

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

Decision rationale: As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, benzodiazepines 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. Studies have shown that tolerance to hypnotic effects develops rapidly and tolerance to anxiolytic effects occurs within months. It has been found that long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. As such the request for 1 prescription of Valium 5mg #90 is not medically necessary.