

<b>Case Number:</b>	CM14-0087711		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	07/05/2011
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	06/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2014

### 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 Physical Medicine and Rehabilitation, and is licensed to practice in Nevada. 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 30 year-old male who was reportedly injured on 7/5/2011. The mechanism of injury is noted as an industrial injury. The most recent progress note, dated 5/28/2014. Indicates that there are ongoing complaints of chronic low back pain. The physical examination demonstrated lumbar spine: flexion 30 with pain, extension 15 with facet loading pain. Positive tenderness to palpation of the lumbar facet. Straight leg is positive on the left at 30. Tenderness of the thoracolumbar fascia especially at T9-10. Motor strength is 5-/5 in the left lower extremity. Paresthesia's in the left 04-5 dermatomes. Mildly antalgic gait. No recent diagnostic studies are available for review. Previous treatment includes lumbar epidural steroid injection, medications, medications, and conservative treatment. A request was made for Percocet 10/3.5 mg #90 with 5 refills, lorazepam 0.5 mg #30 with 5 refills, Celebrex 200 mg #65 refills, and was not certified in the pre-authorization process on 6/4/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg, 10mg three times a day #90, 5 Refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines When to Discontinue Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain: Opioids, Criteria for Use When to Continue Opioids When to Discontinue Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74, 78, 93.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines support short-acting opiates like Percocet for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic low back pain; however, there is no clinical documentation of improvement in their pain or function with the current regimen. As such, this request is not considered medically necessary.

**Lorazepam 0.5mg every night #30, 5 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 -9792.26; MTUS (Effective July 18, 2009) Page(s): 24.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines do not support benzodiazepines (Ativan) for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. As such, this request is not considered medically necessary.

**Celebrex 200mg twice a day #60, 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), gastrointestinal symptoms and cardiovascular riskCelebrex. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter: Anti-Inflammatory Medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 22,30, 70.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines support the use of Celebrex in select clinical settings of acute and chronic pain in conditions for which non-steroidal anti-inflammatory drugs are recommended, but there is a significant risk of gastrointestinal complications. Review of the available medical records, reports chronic low back pain since 2011, but fails to document any risk or signs/symptoms of gastrointestinal complications. Furthermore, the guidelines only recommend 200mg a day. Given the lack of clinical documentation to justify deviation from the guidelines, this request is not considered medically necessary.