MAXIMUS Federal Services

Case Number:	CM14-0202488		
Date Assigned:	12/15/2014	Date of Injury:	09/11/2011
Decision Date:	02/05/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/03/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 33-year old employee with date of injury of 9/11/11. Medical records indicate the patient is undergoing treatment for chronic pain, multifactorial; chronic low back pain, L4-S1 degenerative disc disease (DDD); thoracic DDD; facet arthropathy and T9-10 protrusion; chronic myofascial pain D/O; overweight and tobacco user. Subjective complaints include failure to receive benefit from TENS, ablation or Cymbalta. Objective findings include unremarkable sensory exam and stable gait. She has diffuse palpatory tenderness in the bilateral paraspinal and bilateral PSIS is worse on the right. Her lying straight leg is exacerbated LBP beyond 45 degrees. She has adaptive myofascial muscle shortening on the hamstring. Urine analysis revealed preliminary point of care was opioid positive. Treatment has consisted of bilateral L3, L4 and L5 medial branch radiofrequency ablation under fluoroscopy with IV sedation (1/9/14), physical therapy, TENS, lumbar brace, Zipsor, Gralise, Norco and Percocet. The patient started a functional restoration program, but failed to complete it. She failed an ablation procedure and Cymbalta. The utilization review determination was rendered on 11/13/14 recommending non-certification of Percocet 5/325 MG By Mouth As Needed #60 and Smoking Cessation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325 MG By Mouth As Needed #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids.

Decision rationale: Percocet (oxycodone with acetaminophen) is a short-acting opioid. Chronic pain guidelines and ODG do not recommend opioid "except for short use for severe cases, not to exceed 2 weeks" and "Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficultly weaning." Medical documents indicate that the patient has been on Percocet for over a year, in excess of the recommended 2-week limit. Additionally, indications for when opioids should be discontinued include if there is no overall improvement in function, unless there are extenuating circumstances. As such, the request for Percocet 5/325mg #60 is not medically necessary.

Smoking Cessation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: www.uptodate.com, smoking cessation .

Decision rationale: MTUS is silent regarding smoking cessation. Up-to-date recommendations were consulted.Summary and recommendations was from Up-to-date. One approach to smoking cessation is the five-step algorithm called the 5 A's (Ask, Advise, Assess, Assist, Arrange) (table 1 and table 2). (See 'Introduction' above.). Assessing tobacco use status during healthcare visits increases the likelihood of smoking-related discussions between patients and clinicians, as well as increases smoking cessation rates. (See 'Assessment of use and exposure' above. All smokers should be advised to quit smoking. Even brief advice to quit has been shown to increase quit rates. (See 'Advise smoking cessation' above.). For smokers who are willing to quit, we recommend that smokers be managed with a combination of behavioral support and pharmacologic therapy (Grade 1B). Combination therapy is superior to either behavioral intervention or pharmacologic therapy alone. (See 'Treatment options' above.). -We suggest that the maximal behavioral intervention acceptable to the patient be used. In most settings, behavioral intervention generally consists of brief clinician counseling in the office, but smokers should also be referred to a free telephone quitline for continued counseling support. In the United States, this can be accessed through a national toll-free number (1-800-QUIT-NOW). (See 'Treatment options' above and Behavioral approaches to smoking cessation".)-With a few exceptions, choice of medication is generally based on patient preference after discussion with a clinician. (See "Pharmacotherapy for smoking cessation in adults", section on 'Initiating therapy'.). Smokers who fail to quit on an adequate trial of first-line pharmacotherapy may benefit from second line pharmacotherapy. We also attempt to intensify behavioral counseling.

(See "Pharmacotherapy for smoking cessation in adults", section on 'Patients who fail to quit' and "Behavioral approaches to smoking cessation".). We suggest that patients who successfully quit but experience relapse be treated with a pharmacologic agent that previously helped the patient to achieve abstinence and was tolerable (Grade 2C). Enhancing treatment by adding another pharmacologic agent or more intensive behavioral support can also be considered. (See 'Relapse' above and "Pharmacotherapy for smoking cessation in adults", section on 'Relapse'.). For smokers who are not ready to quit, the clinician's role is to assess the patient's perspective of the risks and benefits of continuing to smoke in order to help the smoker to begin to think about quitting. Smokers can also be advised about the health risks of secondhand smoke exposure to their household members and urged to commit to keeping their home and car smoke-free, especially if children are present. Clinicians can use motivational interviewing techniques for smokers not ready to quit. (See "Behavioral approaches to smoking cessation", section on 'Patients not ready to quit: Motivational Interviewing'.). The treating physician has not provided a medical rationale as to why smoking cessation is needed at this time. The treating physician has provided no evidence that she is a candidate for spinal fusion and no evidence that the patient is ready to start smoking cessation. As such, the request for Smoking Cessation is not medically necessary.