MAXIMUS Federal Services

Case Number:	CM15-0002852		
Date Assigned:	01/14/2015	Date of Injury:	08/29/2005
Decision Date:	03/23/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Arizona
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 59-year-old male with a date of injury of 08/29/2005. The mechanism of injury was not provided. His diagnoses included degeneration of intervertebral disc, lumbosacral spondylosis without myelopathy, and spinal stenosis of the lumbar region. The mechanism of injury was lifting. Past treatments were not provided. His surgical history includes anterior and posterior fusion at L3 to S1 on 12/17/2009. On 12/15/2014, the patient complained of low back pain that was moderate to severe, which improved with his medications. Physical examination noted lumbar range of motion was restricted with pain. There was guarding and muscle spasms were present. The patient stated his current medication regimen has decreased his pain level and allowed him to improve his activities of daily living. He has denied any adverse side effects with the medication. His current medications are fentanyl patch 100 mcg/hr 1 every 48 hours, Percocet 10/325 mg 1 every 4 to 6 hours for severe pain, Soma 350 mg 1 tablet 3 times a day for muscle spasms, and Xanax 0.5 mg once daily. The treatment plan included continuing his medications. He also stated his pain level is worse without his medications and he has severe withdrawal symptoms without them. The Request for Authorization Form, dated 10/27/2014, was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xanax 0.5mg #30: Upheld

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

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

Decision rationale: The request for Xanax 0.5mg #30 is not medically necessary. The patient complained of back pain. The California MTUS Guidelines do not recommend the long term use of benzodiazepines, of which Xanax is part, because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit their use to 4 weeks. The injured worker has been prescribed Xanax for at least 6 months. This exceeds the guideline recommendations for short term therapy. There was lack of efficacy of the medication documented to support the continued use, and the frequency was not provided in the request as submitted. Therefore, based on the documents provided, the request is not medically necessary.

Fentanyl Patches 100mcg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78,86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Page(s): 47.

Decision rationale: The request for fentanyl patches 100mcg #15 is not medically necessary. The California MTUS Guidelines do not recommend fentanyl patches as a first line of therapy. Fentanyl is an opioid analgesic with potency 8 times that of morphine. The documentation provided failed to include evidence of objective decrease in pain and increase in functional improvement with the use of the fentanyl patches. There was not any documentation of whether the injured worker had any aberrant drug taking behaviors. As submitted, the documentation failed to address the frequency of the medication. Therefore, the request is not medically necessary.

Soma 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: The request for Soma 350mg #60 is not medically necessary. According to the California MTUS Guidelines, Soma is not recommended and indicated for long term use. It is a commonly prescribed centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate. According to the documentation provided, the injured worker has

been taking this medication in excess of 6 months. Therefore, it is not supported as the guidelines do not recommend for long-term use. As submitted, the request failed to address the frequency of the medication. As such, the request is not medically necessary.

Percocet 10/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78,86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, 4) On-Going Management Page(s): 78.

Decision rationale: The request for Percocet 10/325mg #180 is not medically necessary. According to the California MTUS Guidelines, Percocet is oxycodone/acetaminophen, and is an opioid. The California MTUS Guidelines state ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, required with the use of opioids for ongoing pain management. There is no documentation in the medical record of the patient having any significantly decreased level of pain or functional capabilities with the use of this medication. The patient continues to have significant levels of pain with the use of the current medication regimen, and continues to have complaints of constant and severe low back pain. The documentation lacks a complete and accurate pain assessment, and an assessment of any aberrant and any side effects. As submitted, the request failed to address the frequency of the medication. As such, the request is not medically necessary.