

Case Number:	CM15-0004822		
Date Assigned:	01/16/2015	Date of Injury:	09/06/2006
Decision Date:	03/13/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/09/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 66 year old female sustained a work related injury on 09/06/2006. According to a progress report dated 10/28/2014, the injured worker complained of increased pain of the right lower extremity for the past four days. She noted pain in the low back, increased pain radiating down the right lower extremity, radiation laterally down to the calf and numbness affecting both legs including her feet. She had difficulty with any long-term walking, standing, bending and twisting. She complained of pain in both knees. Treatments have included medication, physical therapy and lumbar epidural steroid injections. Medications included Percocet for breakthrough pain and Gabapentin for neuropathic pain and Robaxin on a daily basis for muscle spasms. Pain was rated 7 on a scale of 0-10 with medications and 10 without medications. The injured worker noted 30 percent improvement of function and 30 percent reduction in pain with current medication regimen. She noted improved ability to participate in her activities of daily living including self-care needs such as bathing, cooking, cleaning and light household chores. Medications allowed her to continue grocery shopping and assist in the care of her husband who was noted to be quire ill. Medications also allowed her to aggressively participate in physical therapy. According to the provider, she showed no evidence of drug seeking behavior. Diagnoses included low back pain with MRI evidence (June 6, 2011) of compression fracture of L5, grade 1 spondylolisthesis of L4 on L5, 3 mm disc bulge at L3-4, and moderate degenerative changes in the lumbar spine, right lower extremity radicular symptoms, bilateral hip trochanteric bursitis and bilateral knee pain with significant degenerative joint disease. A urine drug screen

dated 07/16/2014 and 10/28/2014 was submitted for review. According to a supplemental report dated 11/17/2014, the injured worker signed a pain medication agreement and remained compliant with the terms of the agreement. The urine drug screen results were noted to be consistent with the injured worker's prescribed medication and also detected in her results were Lorazepam and Tramadol. The injured worker was noted to receive Tramadol from another physician on a nonindustrial basis and was utilizing a topical compounded medication with Tramadol. On 12/22/2014, Utilization Review non-certified Percocet 5/325mg #150 and Tad cream #360 Grams. In regard to the Tad cream and Percocet, the Utilization Review physician noted that there were no objective functional gains from prior medication therapy. A toxicology screen on 10/28/2014 was positive for oxycodone, oxymorphone, acetaminophen, gabapentin, lorazepam and tramadol. The test was noted to be consistent; however there was no mention of any recent use of oxymorphone, lorazepam, and tramadol. There was no supporting pain contract, pill count or CURES report submitted for review. Guidelines cited for this review included CA MTUS ACOEM Low Back Complaints and Knee Complaints and CA MTUS Chronic Pain Medical Treatment Guidelines Opioids. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325mg #150: 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 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 difficulty weaning. Medical documents indicate that the patient has been on Percocet for several months, 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. The treating physician does document some pain level improvement, however, does not document overall improvement in function, which is required for continued use of this medication. As such, the request for Percocet 5/325mg #150 is not medically necessary.

Tad Cream #360G: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Pain, Compound creams

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS states that the only FDA- approved NSAID medication for topical use includes diclofenac, which is indicated for relief of osteoarthritis pain in joints. Tramadol would not be indicated for topical use in this case. As such, the request for Tad Cream #360G is not medically necessary.