

Case Number:	CM15-0007079		
Date Assigned:	01/26/2015	Date of Injury:	08/22/2003
Decision Date:	04/10/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/13/2015

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
 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:

The injured worker is a 64 year old male with an industrial injury dated 08/22/2003 resulting in a back injury. The mechanism of injury is not documented. He presents on 12/09/2014 post lumbar fusion 08/11/2014. He had started physical therapy which he thinks is helping. He is currently having left lower extremity pain radiating into his inner thigh up to his groin. The provider documents the medications are beneficial to the patient and he has no side effects. Physical exam of the lumbar spine showed well healed surgical scar. There was significant tenderness and tightness to palpation with trigger points throughout the lumbosacral spine. Range of motion was restricted. Diagnoses were failed low back pain syndrome with continued multimodality pain, post lumbar 4 - 5 and lumbar 5 - sacral 1 fusion, lumbar facet osteoarthritis, confirmed by MRI, lumbar radiculopathy and situational depression. Prior treatments include pain management, exercises, physical therapy, epidural steroid injections and surgery. He continues on medications. On 12/23/2014 Utilization Review non-certified the request for Percocet 10/325 # 120 citing MTUS Guidelines. The request for Valium 5 mg # 90 was also non-certified. MTUS Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percocet (Oxycodone & Acetaminophen), Opioids, Criteria for Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-78 and 88-89.

Decision rationale: This patient presents with low back pain with bilateral lower extremity pain. The current request is for Percocet 10/325 mg #120. For chronic opiate use, the MTUS Guidelines page 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's including analgesia, ADLs, adverse side effects, and adverse behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Review of the medical file indicates that the patient has been utilizing Percocet since at least 05/23/2014. Progress report dated 05/23/2014 noted that "conservative therapies including home exercise, physical therapy, medication management, has not resulted in any significant pain relief nor increased function overall." Progress report dated 07/18/2014 noted a decrease in pain with current medications from average 7-8/10 to 5-6/10. It was noted the patient benefits with chronic pain medication maintenance regimen which allows him to manage his pain and complete necessary activities of daily living. In this case, recommendation for further use of Percocet cannot be supported as there are no discussions regarding specific functional improvement, changes in ADLs or change in work status to document significant functional improvement. Furthermore, urine drug screens are not provided and there are no discussions regarding possible aberrant behaviors or adverse side effects as required by MTUS for opiate management. The treating physician has failed to document the minimal requirements of documentation that are outlined in MTUS for continued opiate use. The requested Percocet IS NOT medically necessary and recommendation is for slow weaning per MTUS.

Valium 5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Weaning of Medications.

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

Decision rationale: This patient presents with low back pain and bilateral lower extremity pain. The current request is for Valium 5 mg #90. The MTUS Guidelines page 24 have the following regarding benzodiazepines, "Benzodiazepines are not recommended for long-term use because long-term efficacies are unproven and there is a risk of dependence. Most guidelines limit 4 weeks." In this case, the patient has been prescribed this medication since at least 05/23/2014 and MTUS Guidelines recommend maximum use of 4 weeks due to, "unproven efficacy and risk of dependence." Given that this medication has been prescribed for long-term use,

recommendation for further use cannot be provided. The requested Valium IS NOT medically necessary.