

Case Number:	CM15-0131713		
Date Assigned:	07/17/2015	Date of Injury:	09/04/2011
Decision Date:	10/21/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/07/2015

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, Hawaii

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 56-year-old male, with a reported date of injury of 09-04-2011. The diagnoses include lumbar sprain, myofascial sprain and strain of lumbosacral spine, degenerative disc disease of lumbosacral spine, and lumbar spondylosis. Treatments and evaluation to date have included Relafen, Prilosec, home exercise program, hot packs, ice packs, and Norco. The diagnostic studies to date were not included in the medical records provided. The follow-up physiatry pain evaluation report dated 06-11-2015 indicates that the injured worker complained of pain in the lower back. The pain was rated 8 out of 10. The objective findings include decreased lumbar lordosis, tenderness to palpation in the lumbosacral spine and lumbar paraspinal muscles with minimal stiffness, painful lumbar range of motion, negative straight leg raise test, a wide-based and slightly antalgic gait, and use of a single point cane. The treatment plan included Tylenol with Codeine and Celebrex. The injured worker was permanent and stationary. The request for authorization was dated 06-08-2015. The treating physician requested Celecoxib 20mg #30 with two refills (date of service: 06-11-2015) and Acetaminophen-Codeine 300-30mg #30 with two refills (date of service: 06-11-2015). On 06-24-2015, Utilization Review (UR) non-certified the request for Celecoxib 20mg #30 with two refills (date of service: 06-11-2015) and Acetaminophen-Codeine 300-30mg #30 with two refills (date of service: 06-11-2015).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro DOS: 6/11/15 APAP/Codeine 300/30mg #30 with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The patient presents with low back pain. The current request is for Retro DOS 06/11/2015 APAP/Codeine 300/30mg #30 with 2 refills. The treating physician's report dated 06/11/2015 (3B) states, "The patient at this point is not taking any medication and pain rating is 8 and without medication is 9 and 10." The patient is currently permanent and stationary. Medical records do not show a history of APAP/Codeine use. The MTUS Guidelines page 76 to 78 under criteria for initiating opioids recommend that reasonable alternatives have been tried, considering the patient's likelihood of improvement, likelihood of abuse, etc. MTUS goes on to states that baseline pain and functional assessment should be provided. Once the criteria have been met, a new course of opioids may be tried at this time. In this case, despite conservative treatments the patient remains symptomatic. The physician would like to trial APAP/Codeine to determine the efficacy in terms of pain relief and functional improvement. The current request is medically necessary.

Retro DOS: 6/11/15 Celecoxib 20mg #30 with 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The patient presents with low back pain. The current request is for Retro DOS 06/11/2015 Celecoxib 20mg #30 with 2 refills. The treating physician's report dated 06/11/2015 (3B) states, "The patient at this point is not taking any medication and pain rating is 8 and without medication is 9 and 10." Medical records do not show a history of Celebrex use. The MTUS Guidelines page 22 on anti-inflammatory medication states that anti-inflammatories are the traditional first-line treatment to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. In this case, MTUS recommends anti-inflammatory medications as first-line treatment for pain. Given the patient's significant symptoms, a trial of Celecoxib is appropriate to determine its efficacy in terms of pain relief and functional improvement. The current request is medically necessary.