

Case Number:	CM15-0161900		
Date Assigned:	08/28/2015	Date of Injury:	06/20/1997
Decision Date:	09/30/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	08/18/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 58 year old female sustained an industrial injury to the low back on 6-20-97. Recent treatment consisted of intrathecal pump and medication management. Documentation did not disclose recent magnetic resonance imaging. In a pain management consultation dated 4-1-15, the injured worker complained of ongoing low back pain. The injured worker reported that her intrathecal pump provided fairly good control of low back and lower extremity pain. The injured worker took Celebrex daily to help reduce her overall inflammation. The injured worker reported that her current medication regimen provided symptomatic relief and restorative function by reducing her pain by about 50%. In a pain management progress report dated 8-6- 15, the injured worker complained of pain to the low back and at the pump site, rated 8 out of 10 on the visual analog scale. Physical exam was remarkable for abdomen clean, dry and intact with no signs of erythema or rebound tenderness around the pump site. Current diagnoses included lumbar spine radiculopathy, lumbar failed back syndrome, shoulder sprain and strain and shoulder degenerative joint disease. The treatment plan included renewing prescriptions for Celebrex, Hydrochlorothiazide and Percocet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200mg quantity 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex, Non Steroidal Anti Inflammatory Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects, p68-71.

Decision rationale: The claimant has a remote history of a low back injury occurring in June 1997 and continues to be treated for chronic pain including a diagnosis of failed back surgery syndrome. Treatments include an intrathecal drug delivery system with infused medications including Dilaudid. When seen, pain was rated at 8/10. She was having pain at the pump implantation site and was having back pain. Physical examination findings included a BMI of 36. There was pain with lumbar flexion and extension. The pump was refilled and reprogrammed. Percocet and Celebrex were refilled. Guidelines recommend an assessment of gastrointestinal symptoms and cardiovascular risk when NSAIDs are used. The claimant does not have identified risk factors for a gastrointestinal event. The claimant is under age 65 and has no history of a peptic ulcer, bleeding, or perforation. There is no documented history of dyspepsia secondary to non-steroidal anti-inflammatory medication therapy. In this clinical scenario, guidelines do not recommend prescribing a selective COX-2 medication such as Celebrex (celecoxib) over a non-selective medication. The request is not medically necessary.

Percocet 10/325mg quantity 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Opioids, criteria for use, p76-80 (2) Opioids, dosing, p86.

Decision rationale: The claimant has a remote history of a low back injury occurring in June 1997 and continues to be treated for chronic pain including a diagnosis of failed back surgery syndrome. Treatments include an intrathecal drug delivery system with infused medications including Dilaudid. When seen, pain was rated at 8/10. She was having pain at the pump implantation site and was having back pain. Physical examination findings included a BMI of 36. There was pain with lumbar flexion and extension. The pump was refilled and reprogrammed. Percocet and Celebrex were refilled. Percocet (oxycodone/acetaminophen) is a short acting combination opioid often used for intermittent or breakthrough pain. In this case, the claimant is receiving intrathecal opioid medication. There is no documentation that the Percocet being prescribed is currently providing decreased pain, an increased level of function, or improved quality of life. Continued prescribing was not medically necessary.