MAXIMUS Federal Services

Case Number:	CM15-0218296		
Date Assigned:	11/10/2015	Date of Injury:	12/15/2004
Decision Date:	12/29/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	11/05/2015

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: Texas, California
Certification(s)/Specialty: Family Practice

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 is a 51 year old female patient, who sustained an industrial-work injury on 12-15-04. She sustained the injury due to a fall on the balcony surface. The diagnoses include lumbago, lumbar degenerative disc disease (DDD) and chronic pain syndrome. Per the doctor's note dated 9-24-15, she had complains of low back pain, left hip pain and left shoulder pain; numbness of the front of the thigh, burning in the lower thigh, aching in the shoulder and back; average pain rated 6-7 out of 10 on the pain scale but today the pain rated 4 out of 10. She reported with medications she was independent in activities of daily living (ADL). Per the treating physician report dated 9-24-15 work status is retired. The physical exam revealed limited range of motion of the lumbar spine, pain with hypersensitivity of the skin, muscle spasms, positive straight leg raise bilaterally, and she walks bent over. The physician indicates that he will prescribe Percocet for back shoulder and hip pain and change from Norco. The medications list includes Norco, Motrin, Neurontin, Trazadone, Vicodin, Robaxin, Cymbalta, Klonopin, Methocarbamol since at least 1-28-15 and Percocet since at least 9-25-15. She had a lumbar MRI on 6/5/2013; left shoulder MRI on 3/5/14.Treatment to date has included pain medication, aqua therapy, chiropractic, acupuncture, Transcutaneous electrical nerve stimulation (TENS) and other modalities. The medical records do not indicate decreased pain, increased level of function or improved quality of life. The records do not indicate least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief and how long the pain relief lasts. The request for authorization date was 9-25-15 and requested services included Percocet 10-325 MG (DND Until 10-22-2015) Qty 90 and Methocarbamol 500 MG Qty 60. The original Utilization review dated 10-2-15 non-certified the request for Percocet 10-325 MG (DND Until 10-22-2015) Qty 90 and Methocarbamol 500 MG Qty 60 as not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 MG (DND Until 10/22/2015) Qty 90: Upheld

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

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

Decision rationale: Percocet 10/325 MG (DND until 10/22/2015) Qty 90. Percocet contains oxycodone and acetaminophen. Hydrocodone is an opioid analgesic. According to the cited guidelines, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." The records provided do not specify that that patient has set goals regarding the use of opioid analgesic. The treatment failure with non-opioid analgesics is not specified in the records provided. Other criteria for ongoing management of opioids are: "The lowest possible dose should be prescribed to improve pain and function. Continuing review of overall situation with regard to non-opioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects...Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." The records provided do not provide a documentation of response in regards to pain control and objective functional improvement to opioid analgesic for this patient. The continued review of the overall situation with regard to non-opioid means of pain control is not documented in the records provided. As recommended by the cited guidelines a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these are not specified in the records provided. The response to a lower potency opioid like tramadol for chronic pain is not specified in the records provided. A recent urine drug screen report is not specified in the records provided. This patient does not meet criteria for ongoing continued use of opioids analgesic. The medical necessity of Percocet 10/325 MG (DND Until 10/22/2015) Qty 90 is not established for this patient, based on the clinical information submitted for this review and the peer reviewed guidelines referenced. If this medication is discontinued, the medication should be tapered, according to the discretion of the treating provider, to prevent withdrawal symptoms.

Methocarbamol 500 MG Qty 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Methocarbamol 500 MG Qty 60. Robaxin / Methocarbamol is a muscle relaxant. California MTUS, Chronic pain medical treatment guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Per the guideline, "muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. The level of the pain with and without this medication is not specified in the records provided. The need for methocarbamol on a daily basis with lack of documented improvement in function is not fully established. Muscle relaxants are not recommended for long periods of time. Evidence of an acute exacerbation is not specified in the records provided. The medical necessity of Methocarbamol 500 MG Qty 60 is not established for this patient at this juncture.