

<b>Case Number:</b>	CM15-0219484		
<b>Date Assigned:</b>	11/12/2015	<b>Date of Injury:</b>	04/26/2007
<b>Decision Date:</b>	12/28/2015	<b>UR Denial Date:</b>	10/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/09/2015

### 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, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 61 year old female, who sustained an industrial injury on 4-26-2007. She reported knee, back and right wrist pain. According to physician documentation, the injured worker was diagnosed with left and right knee pain, radiculopathy of the lumbosacral region, back muscle spasms and major depressive disorder. Subjective findings dated 7-17-2015, were notable for constant sharp and burning pain that radiated down both lower extremities and feet, rating her pain 4-6 out of 10. Objective findings dated 8-14-2015, were notable for lumbar spine tenderness on palpation midline and paraspinal area with 45 degree flexion and 20 degree extension and tenderness on palpation of both knees with full range of motion not determined secondary to pain. On 7-27-2015, an MRI of the left lower extremity was performed revealing moderately severe, degenerative arthritis with severe degenerative change in the medial compartment, and a mild sprain of medial collateral ligament. Treatments to date have included Tramadol (with some relief), Soma, Percocet 10mg, Mobic 15mg, and Baclofen 10mg. The Utilization Review determination dated 10-5-2015 did not certify retrospective treatment/service requested for Percocet 10mg #90, Mobic 15mg # 30 and Baclofen 10mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10mg #90: Upheld**

**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, Opioids, specific drug list. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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 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 #60 is not medically necessary.

**Mobic 15mg #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, specific drug list & adverse effects.

**Decision rationale:** MTUS states "Meloxicam is a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. See NSAIDs." MTUS guidelines for NSAIDs are divided into four usage categories: Osteoarthritis (including knee and hip), Back Pain; Acute exacerbations of chronic pain, Back Pain; Chronic low back pain, and Neuropathic pain. Regarding "Osteoarthritis (including knee and hip)", medical records do not indicate that the patient is being treated for osteoarthritis, which is the main indication for meloxicam. Regarding "Back Pain- Acute exacerbations of chronic pain", MTUS recommends as a second-line treatment after acetaminophen. Medical records do not indicate that the patient has "failed" a trial of Tylenol alone. Regarding "Back Pain- Chronic low back pain", MTUS states, "Recommended as an option for short-term symptomatic relief". The medical records indicate that the patient has been prescribed meloxicam longer than "short-term". Regarding "Neuropathic pain", MTUS writes "There is inconsistent evidence for the use of these medications to treat long term neuropathic pain, but they may be useful to treat breakthrough

and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain". Medical records do not indicate that the patient is being treated for osteoarthritis. As such, the request for Mobic 15mg #30 is not medically necessary at this time.

**Baclofen 10mg #30:** Upheld

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

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

**Decision rationale:** Baclofen is classified as a muscle relaxant. MTUS states "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP . . . 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." Additionally, MTUS states "Baclofen (Lioresal, generic available): The mechanism of action is blockade of the pre- and post-synaptic GABAB receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain (trigeminal neuralgia, non-FDA approved). (ICSI, 2007)." The treating physician has not provided documentation of muscle spasms related to multiple sclerosis or spinal cord injuries. Additionally, the treating physician has not provided documentation of trials and failures of first line therapies. As such the request for Baclofen 10mg #30 is not medically necessary.