

Case Number:	CM15-0012115		
Date Assigned:	01/29/2015	Date of Injury:	11/01/2002
Decision Date:	03/25/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	01/21/2015

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 57 year old male, who sustained an industrial injury on 11/01/2002. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. Diagnoses included other internal derangement of the knee, lumbago, muscle spasm, lumbosacral spondylosis without myelopathy, and insomnia due to medical condition classified elsewhere. Treatment to date has included medication regimen, home exercise program, and magnetic resonance imaging. In a progress note dated 01/12/2015 injured worker reported increased pain to the bilateral lower extremities with the left greater than the right with a rating of seven out of ten and worst pain at an eight to nine out of ten but is reduced to a three out of ten with medication regimen. The injured worker also has complaints of low back pain that radiates to the right lower extremity, right knee pain, and right iliac crest pain. The treating physician requested Percocet and Diazepam noting that these medications are "appropriate and indicated". On 01/20/2015 Utilization Review modified the requested treatments Percocet 10/325mg for a quantity of 120 with 0 refills to Percocet 10/325mg for a quantity of 60 without refills and Diazepam 5mg for a quantity of 30 with 2 refills to Diazepam 5mg for a quantity of 15 without refills, noting the California Medical Treatment Utilization Schedule, 2009, Chronic Pain, page 78 and page 24.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg, #120, 0 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic, pain Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 88-89.

Decision rationale: The patient presents with significant low back pain that radiates out to the lateral posterior buttock and hip area and down to both knees. The current request is for Percocet 10/325mg, #120, 0 refills. The treating physician states on 1/12/15 (B136) "prescription for Percocet was written end of last week. I believe these treatments are appropriate and indicated. Patient is also encouraged to seek nonpharmacologic, nonsurgical measures". Percocet contains a combination of acetaminophen and Oxycodone. Oxycodone is an opioid pain medication. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "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 4As (analgesia, ADLs, adverse side effects, and aberrant 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. In this case, there is no discussion regarding ADLs or functional improvements and there is no documentation of side effects or aberrant behaviors. MTUS guidelines require much more thorough documentation for ongoing opioid usage. The current request is not medically necessary and the patient should be slowly weaned per MTUS guidelines. Recommendation is for denial.

Diazepam 5mg, #30, 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 24.

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

Decision rationale: The patient presents with significant low back pain that radiates out to the lateral posterior buttock and hip area and down to both knees. The current request is for Diazepam 5mg, #30, 2 refills. On 1/12/15 (B139) the treating physician prescribes "Diazepam 5mg oral tablet Sig: 1-2 tab/day prn spasm". Diazepam is a benzodiazepine. It affects chemicals in the brain that may become unbalanced and cause anxiety. Diazepam is used to treat anxiety disorders or muscle spasms. MTUS states that Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. In this case, the clinical records document that the patient has been using Diazepam since at 5/9/12 (B89). The sig and quantity requested is consistent with use less than 4 continuous weeks if the IW took two pill any one time during the month. This would result in at least one day in which the IW did not take the medication. Therefore, the

medication is not taken continuously and on a chronic basis. The current request is medically necessary and the recommendation is for authorization.