MAXIMUS Federal Services

Case Number:	CM15-0177712		
Date Assigned:	09/18/2015	Date of Injury:	10/24/1986
Decision Date:	10/22/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/10/2015

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: Maryland, Texas, Virginia
Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 65 year old male, who sustained an industrial injury on 10-24-1986. The injured worker was diagnosed chronic bilateral knee pain, hypogonadism, failed back surgery syndrome of the lumbar spine with radiculopathy. The request for authorization is for: one prescription of Percocet 5-325mg #240, one prescription of Marinol 50mg #30, one prescription of Demerol 50mg #240, and one prescription of Testosterone Cypionate 200mg per ml 0.65ml. The UR dated 8-27-2015: modified certification of one prescription of Percocet 5-325mg #150, certified one prescription of Demerol 50mg #240, non-certified one prescription of Marinol 50mg #30, and certified one prescription of Testosterone Cypionate 200mg per ml 0.65ml. On 2-17-2015, he is reported to be on permanent disability. Demerol and Oxycodone are indicated to help with increased function and activities of daily living and to decrease his pain. No side effects are noted. There is notation of a signed pain contract dated 1-27-2015. He rated his average pain 7-8 out of 10, pain with medications 6 out of 10 and without medications 10 out of 10. No aberrant behaviors or adverse effects are noted. Marinol is noted to be for spasms, not pain. On 3-2-2015 he reported low back, bilateral hip and knee pain. There is notation that night-time cramping is well controlled with Marinol. He is reported to have an antalgic gait with restricted lumbar range of motion. On 5-19-2015, Percocet 5-325 one to two tablets is noted as working well with only 2 episodes of nausea, and reduction in pain and increased function. Pain average is rated 7-8 out of 10, with medications 6 out of 10, and without medications 10 out of 10. On 7-6-2015, he reported numbness to be improved; left knee pain is work than right. He is reported to take Marinol for cramping. The provider noted "he does have significant cramping due to his work related injury and subsequent pain and surgery with restless leg syndrome". On 8-20-2015, his pain average is rated 7.25 out of 10, with medications 6 out of 10, and without

medications 10 out of 10. The provider noted Marinol to have helped for years with nocturnal muscle spasms. The treatment and diagnostic testing to date has included: urine drug screen (1-27-2015), CURES (1-20-2015), medications, nerve root block (6-30-2015).

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325mg, #240: 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, long-term assessment. 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 difficultly weaning. Medical documents indicate that the patient has been on Percocet for several months, in excess of the recommended 2-week limit. Additionally, indications for when opioids should be discontinued includes "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, #240 is not medically necessary.

Marinol 50mg, #30: 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), Pain (Chronic) Cannabinoids 2015.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cannabinoids.

Decision rationale: MTUS states "Not recommended - In total, 11 states have approved the use of medical marijuana for the treatment of chronic pain, but there are no quality controlled clinical data with cannabinoids. Restricted legal access to Schedule I drugs, such as marijuana, tends to hamper research in this area. It is also very hard to do controlled studies with a drug that is psychoactive because it is hard to blind these effects. At this time, it is difficult to justify advising patients to smoke street grade marijuana, presuming that they will experience benefit, when they may also be harmed. (Mackie, 2007) (Moskowitz, 2007) One of the first dose-response studies of cannabis in humans has found a window of efficacy within which healthy volunteers experienced relief from experimentally induced pain. But although mid-range doses

provided some pain relief, high doses appeared to exacerbate pain. (Wallace, 2007) Results of a double-blind crossover study suggest that smoked cannabis may reduce pain intensity for patients with neuropathic pain, although the Food and Drug Administration (FDA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute for Drug Abuse (NIDA) report that no sound scientific studies support the medicinal use of cannabis. Psychoactive effects were also seen, including feeling high, although these were less apparent at the lower dose. Of more concern, were effects on cognitive performance, which in this chronic pain population was at or below the threshold for impairment already at baseline. Cannabis use was associated with modest declines in cognitive performance, particularly learning and recall, especially at higher doses. The finding necessitates caution in the prescribing of medical marijuana for neuropathic pain, especially in instances in which learning and memory are integral to a patient's work and lifestyle. (Wilsey, 2008)" Guidelines recommend against the use of cannabinoids. As such, the request for Marinol 50mg, #30 is not medically necessary.