

Case Number:	CM14-0155887		
Date Assigned:	09/25/2014	Date of Injury:	11/20/2010
Decision Date:	10/27/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/23/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 59 year old male with a date of injury of 11/20/2010. He has neck pain and low back pain. A MRI on 02/05/2011 revealed L5 pars fractures bilaterally and a grade 1 spondylolithesis at L5 on S1. There was a 4 mm disc protrusion impinging on the anterior thecal sac. There was also a right lateral annular tear at L4-L5. On 02/23/2012 a MRI revealed a laminotomy change. On 08/29/2012 a cervical MRI revealed L3-L4 moderate canal stenosis with bilateral neural foraminal stenosis. On 09/19/2012 he was taking Norco. On 01/04/2013 he was P&S. 01/14/2014 he had neck pain and low back pain 4 -6/10. The back pain radiated to his right leg and knee. He was taking hydrocodone/APAP 5/325, Omeprazole and LidoPro topical ointment. On 04/14/2014 it was noted that his primary care physician follows up his kidney disease. He was taking Norco, Flexeril and Omeprazole. The request was for Orphenadrine, Norco and Omeprazole. On 04/15/2014 the BUN was 27 and the creatinine was 1.78. AST and ALT were normal. Hb was 15.9. The estimated GFR was 41. On 05/16/2014 he was taking hydrocodone/APAP 5/325, Orphenadrine and Omeprazole. On 08/05/2014 he had neck pain and low back pain. The back pain radiated down the right leg to the knee and was 6/10. On 08/05/2014 the BUN was 16 and the creatinine was 1.43. ALT was 33 and normal. Hb was 15.4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg, #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) proton pump inhibitors (PPIs)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Harrison's Principles of Internal Medicine, 18th Edition. 2011.

Decision rationale: MTUS and ODG do not comment specifically on the need to Omeprazole. There is no documentation of ongoing gastrointestinal complaints. There is no documentation of peptic ulcer disease. There is no documentation of long term use of NSAIDS. Long term use of proton pump inhibitors, especially at the BID dose, has been associated with benign gastric growth from acid suppression. This resolves with discontinuation of Omeprazole. There is insufficient documentation to substantiate the medical necessity of continued long term treatment with Omeprazole.

Orphenadrine Citrate 100mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-sedating muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Non-sedating muscle relaxants

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-65..

Decision rationale: MTUS, Chronic Pain Medical Treatment Guidelines; Muscle relaxants (for pain); recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) 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. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Continued use of this muscle relaxant is not consistent with MTUS and this was previously partially approved for the purpose of weaning this medication. Therefore, this request is not medically necessary.

Hydrocodone/APAP 5/325mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids use in chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80..

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines; (Effective July 18, 2009) Page 78.4) On-Going Management. Actions Should Include:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).(g) Continuing review of overall situation with regard to nonopioid means of pain control.(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The documentation did not meet MTUS Chronic Pain on-going opioid treatment documentation requirements. Therefore, this request is not medically necessary.

Internal Medicine consult for kidneys: 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) Office visits

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Harrison's Principles of Internal Medicine, 18th Edition.

Decision rationale: MTUS and ODG do not mention this clinical issue of consultation for renal disease when the BUN is normal. The patient's BUN of 27 decreased to 16 in 08/2014 indicating that part of the "renal disease" was dehydration pre-renal azotemia. The BUN most recently was normal. The creatinine is still very slightly elevated. However, there is no documentation of active renal disease. Liver function and Hb were normal. He was not taking NSAIDS. Periodic measurement of BUN and creatinine does not require an internal medicine consultation. Therefore, this request is not medically necessary.

Follow up consult for kidneys: 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) Office visits

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Harrison's Principles of Internal Medicine, 18th Edition. 2011.

Decision rationale: MTUS and ODG do not mention this clinical issue of consultation for renal disease when the BUN is normal. The patient's BUN of 27 decreased to 16 in 08/2014 indicating that part of the "renal disease" was dehydration pre-renal azotemia. The BUN most recently was normal. The creatinine is still very slightly elevated. However, there is no documentation of active renal disease. Liver function and Hb were normal. He was not taking NSAIDS. Periodic measurement of BUN and creatinine does not require an internal medicine consultation. This request is not medically necessary.

Lab work: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation McPherson & Pincus: Henry's Clinical Diagnosis and Management by Laboratory Methods, 21st ed. Chapter 8- Interpreting Laboratory Results

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Harrison's Principles of Internal Medicine, 18th Edition. 2011.

Decision rationale: MTUS and ODG do not have criteria for "lab tests". The most recent comprehensive metabolic panel and CBC were normal with the exception of a slight increase in the creatinine. The creatinine should be further monitored. However, the question was a request for the general "lab work" which is not specific and stands for the testing of literally thousands of tests. It is not a specific request and the generalized monitoring of "lab tests" cannot be approved.