MAXIMUS Federal Services

Case Number:	CM14-0036463		
Date Assigned:	06/25/2014	Date of Injury:	06/18/2004
Decision Date:	11/14/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	03/25/2014

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 Family Medicine and is licensed to practice in California. 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:

This case involves a 66-year old correctional officer reported injuries to her right knee and low back after she slipped on some stairs without falling on 6/18/04. She has not worked since the date of injury. She underwent right knee arthroscopic surgery on 8/10/05, spinal fusion from T11-L5 in March of 2007, and right total knee arthroplasty on 3/24/09. She also underwent a gastric bypass in 2007. A 1/4/10 orthopedics AME evaluation notes that the patient is taking Vicodin, Percocet, and Flexeril. On 1/13/13 the patient presented to the emergency room with abdominal pain and was found to have a bleeding duodenal ulcer. She was taking both Celebrex 200 mg and Ibuprofen 1600 mg per day. She underwent laparoscopic surgery the same day. A 5 mm duodenal ulcer was found and repaired. She was discharged on 1/18/14 on IV pantoprazole. There is only one note in the available records from the primary treating doctor with a date prior to the requests being evaluated. It is dated 2/5/14, and is only partially legible. Documentation of current complains includes only persistent back pain. Objective findings appear to be "Back tend mid low L5". Diagnosis is LS disc disease. Plan includes Percocet 5/325, Zanaflex and Omeprazole. There is also a note from a secondary treating doctor dated 11/25/13. It documents cervical and thoracic pain to a 9/10 level. Documented exam abnormalities included suboccipital tenderness, cervical paraspinal spasm, decreased neck range of motion, increased thoracic kyphosis, decreased back range of motion, decreased hip and knee strength bilaterally, and diminished sensation of the left lower extremity. Diagnoses included thoracic or lumbosacral neuritis or radiculitis, brachial neuritis or radiculitis, thoracic spinal stenosis, post-laminectomy syndrome of lumbar spine, cervical spondylosis without myelopathy and degeneration of lumbar or lumbosacreal disc and of cervical disc. Plan included dispensing Omeprazole 20 mg #60, Tramadol ER 150 mg BID #60 and Zanaflex 2 mg QID PRN #60. The patient was given instructions not to start the Omeprazole until 5/13/13, the Zanaflex until 5/13/13, and the

Tramadol until 12/4/13, presumably because she already had a supply of medication that would last until these dates. Percocet 5/325 TID #90 and MS Contin ER 15 mg/12 hrs one tab BID #60 were prescribed. The chart contains a neurological AME evaluation dated 10/7/13 which notes that the patient does not appear to have cervical radiculopathy, but that she does have bilateral carpal tunnel syndrome unrelated to her 6/18/04 injury. The notes from the primary and secondary treating doctor make no statements about the patient's level of function, or about any functional goals.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 2mg #120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Muscle relaxants Page(s): 60, 63-66.

Decision rationale: Per the first reference cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Per the second reference, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In most low back pain patients, they show no benefit and efficacy appears to diminish over time. There is no additional benefit if they are used in combination with non-steroidal anti-inflammatory drugs (NSAIDs). Tizanidine (Zanaflex) is a centrally acting antispasmodic drug. Its side effects include somnolence, dizziness and dry mouth. This patient has been on Tizanidine from at least 2/5/14 through 11/25/14. She appears to have been on a sedating muscle relaxant since at least 1/4/10. During this time she has not made any functional recovery, and has remained totally disabled. In reviewing the medicals provided there is lack of documentation of levels of function or setting functional goals. Therefore, based on the MTUS references cited above and the clinical information provided, this request is not medically necessary.

Omeprazole 20mg #30: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UptoDate, (www.uptodate.com), Overview of the natural history and treatment of peptic ulcer disease; Omeprazole: drug information .

Decision rationale: According to the first reference cited above, the relationship between H. pylori and non-steroidal anti-inflammatory drugs (NSAIDs) use is complex and controversial. The presence of H. pylori is a significant risk factor for complicated ulcers, and its eradication

may reduce the risk of ulcer recurrence. There are no firm guidelines regarding the continuation of antisecretory medication after H. pylori eradication, but its use appears to be appropriate in patients with increased risk. There is some risk of recurrence or exacerbation due to the rebound acid hypersecretion that accompanies discontinuation of potent antisecretory agents. The second reference states that the side effects of long-term (usually over one year) use omeprazole include atrophic gastritis, increased incidence of gastric carcinoid tumors, clostridium difficile-associated diarrhea, increased incidence of osteoporosis related fractures of the hip, spine, or wrist; hypomagnesemia and Vitamin B12 deficiency. The decision to stop Omeprazole in this patient is a complex one. She has a history of a gastrointestinal (GI) bleed requiring surgery due to NSAID use in the past, and she has had a gastric bypass. She does not appear to have been evaluated for H pylori infection. None of her current providers has documented concern about any of these issues, or about the risk of side effects of long-term Omeprazole use. Since abrupt discontinuation of Omeprazole may result in increased risk for ulcer, the request for Omeprazole 20 mg #30 is medically necessary.

Oxycodone/APA 5-325mg #180: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Criteria for Use of Opioids, Steps to Take Before a T.

Decision rationale: Oxycodone is an opioid analgesic. According the guidelines above, opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine in the patient's pain is nociceptive or neuropathic. (Opioids are not generally considered to be first-line therapy for neuropathic pain.) Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. If long-term use of opioids occurs, there is a need for ongoing pain and function assessments, as well as assessments for side effects, of concurrent other treatments, and of concurrent psychological issues. Patients taking opioids sometimes develop abnormal pain, a change in pain pattern, or persistence in pain at higher levels than expected, which are actually a result of taking opioids. This is called opioid hyperalgesia. The clinical findings in this case do not demonstrate that any of the above criteria have been met. There is no documentation that Oxycodone/APAP was introduced individually, with ongoing careful assessment of function. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. No specific functional goals were set or followed. No evaluation has been made for opioid hyperalgesia. This patient has been totally disabled since 2004, and there are no notes documenting any improvement in function. Based on the evidence-based guidelines cited above and the clinical information provided for the review, this request is not medically necessary.