

Case Number:	CM15-0138588		
Date Assigned:	07/28/2015	Date of Injury:	04/08/1999
Decision Date:	09/02/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/17/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 59-year-old male who sustained an industrial injury on 4-8-99. In a progress report dated 6-16-15, the treating physician notes a history of cervical, thoracic, and lumbar strain-sprain with ongoing myofascial pain residuals, severe spondylitic change per an MRI of the cervical spine with cervicogenic headaches, MRI of the lumbar spine reveals severe degenerative joint disease; degenerative disc disease; and facet arthrosis, history of thoracic sprain-strain. The injured worker reports chronic neck and back pain and muscle spasms. He continues to work part-time. Pain is rated as 8 out of 10, at best a 4 out of 10 with medications and 10 out of 10 without medications. He reports a 50% reduction in pain and 50% functional improvement with activities of daily living with the medications but that Norco is not giving him adequate relief. It is noted, he wants to go back to Percocet, which he states works better for him. He is under a narcotic contract and urine drug screens are noted to have been appropriate. Neck and back exam continue to reveal limited range of motion in all planes. Motor strength, sensation and deep tendon reflexes are intact in the upper and lower extremities. Multiple areas of trigger point tenderness is noted in the cervical, thoracic, lumbar and paraspinal musculature. There is hypertonicity in the cervical trapezius and lumbar paraspinals. The treatment plan is Percocet as needed for pain, Ibuprofen for the inflammatory component of pain, Ranitidine to offset the dyspepsia side effect from the non-steroidal anti-inflammatory drug, and resume his exercise regime and self-modifications at work. The requested treatment is Percocet 10-325mg for a quantity of 100 and Ranitidine 150mg for a quantity of 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg Qty 100: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113, 68-69, 67, 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 92.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding ongoing management of opioids "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 non-adherent) drug related behaviors. These domains have been summarized as the '4 A's' (Analgesia, activities of daily living, adverse side effects, and any 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. "Per progress note dated 6/16/15, the injured worker rated his pain 8/10, 4/10 at best with his medications (Tramadol, Norco, ibuprofen), and 10/10 without them. He reported 50% reduction in his pain and 50% functional improvement with activities of daily living with the medications. He stated that Norco was not giving him adequate relief, and that he wanted to go back to Percocet, which he stated worked better for him. Efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. It was noted that urine drug screens have been appropriate; however, no reports were available for review. CURES was not available. I respectfully disagree with the UR physician's denial based upon the lack of clinical indication to escalate the opioid usage. Per the medical records, it appears that Percocet has been prescribed as a substitute for Tramadol and Norco rather than in addition to it. I disagree with the UR rationale that since 50% of the pain is reduced with the current medication management, that it should not be optimized further. The request is medically necessary.

Ranitidine 150 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113, 68-69, 67, 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e. g. , NSAID + low-dose ASA). CPMTG guidelines further specify: Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at

intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardio protection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low. As such, the request is not medically necessary.