

Case Number:	CM15-0147624		
Date Assigned:	08/12/2015	Date of Injury:	06/25/2009
Decision Date:	09/09/2015	UR Denial Date:	07/06/2015
Priority:	Standard	Application Received:	07/30/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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:

This is a 57 year old male with a June 25, 2009 date of injury. A progress note dated May 21, 2015 documents subjective complaints (chronic, severe lower back pain; history of intractable back and right leg pain; pain rated at a level of 10 out of 10 without medications and 5 out of 10 with medications; pain is 10 out 10 today), objective findings (well healed procedure sites on the lumbar spine; tenderness to palpation of the lumbar paraspinals; decreased range of motion of the lumbar spine; positive straight leg raise bilaterally; antalgic gait; decreased strength of the right lower extremity; decreased sensation on the right at L4, L5, and S1), and current diagnoses (lumbar post laminectomy syndrome; thoracic and lumbosacral neuritis or radiculitis; degeneration of lumbar or lumbosacral intervertebral disc; lumbago). Treatments to date have included medications, home exercise, lumbar spine surgery, medial branch block with greater than 85% pain relief and functional improvement lasting greater than one week, back bracing, use of a cane, and imaging studies. The medical record indicates that medications help control the pain. The treating physician documented a plan of care that included Omeprazole 20mg #90 for two months, and Percocet 10-325mg #180.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg; 1 capsule every 12 hrs; #90 X 2 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 68-71.

Decision rationale: The claimant sustained a work-related injury in June 2009 and is being treated for chronic radiating low back pain. Medications are referenced as decreasing pain from 10/10 to 5/10 and allowing for increased mobility, activities of daily living, and ability to exercise. The claimant has a history of medication induced gastritis. When seen, there was a BMI of over 33. There was decreased lumbar range of motion with tenderness. There was an antalgic gait with a cane and he was using a lumbar corset. There was positive right straight leg raising and decreased right lower extremity strength. No oral NSAID medication is being prescribed. Guidelines recommend an assessment of GI symptoms and cardiovascular risk when NSAIDs are used. In this case, the claimant is not taking an oral NSAID. Further investigation of ongoing gastritis for other potentially correctible causes could be considered. The continued prescribing of omeprazole is not medically necessary.

Percocet 10/325mg #180: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines on-going management Page(s): 102.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Opioids, criteria for use, (2) Opioids, dosing Page(s): 76-80, 86.

Decision rationale: The claimant sustained a work-related injury in June 2009 and is being treated for chronic radiating low back pain. Medications are referenced as decreasing pain from 10/10 to 5/10 and allowing for increased mobility, activities of daily living, and ability to exercise. The claimant has a history of medication induced gastritis. When seen, there was a BMI of over 33. There was decreased lumbar range of motion with tenderness. There was an antalgic gait with a cane and he was using a lumbar corset. There was positive right straight leg raising and decreased right lower extremity strength. Percocet was refilled at a MED (morphine equivalent dose) of 90 mg per day. When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Percocet (oxycodone/acetaminophen) is a short acting combination opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. There are no identified issues of abuse or addiction and medications are providing decreased pain. The total MED is less than 120 mg per day consistent with guideline recommendations. Continued prescribing was medically necessary.