

Case Number:	CM15-0190778		
Date Assigned:	10/02/2015	Date of Injury:	07/24/2008
Decision Date:	11/16/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	09/28/2015

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 47 year old male who sustained an industrial injury July 24, 2008. Diagnoses are status post multiple trauma; status post head injury with post-concussive syndrome; status post ORIF (open reduction internal fixation) right elbow fracture with residual stiffness and neuropathic pain; status post ORIF right wrist fracture with residual stiffness; lumbar sprain, strain and right radiculopathy, chronic; status post lumbar surgery; gait disorder due to right lower extremity atrophy and weakness-persistent radiculopathy, worse; status post ORIF pelvic fracture 2008; right knee sprain, strain; chronic pain syndrome with chronic opiate use. Past history included asthma and low back tumor. According to a secondary treating physician's report dated August 26, 2015, the injured worker presented with complaints of pain in the low back, right elbow, right wrist, pelvis and right knee, rated 5-10 out of 10. The pain is better with rest, medication, and ice and worse with walking and sitting for prolonged periods of time. Current medication included Cymbalta, Ambien, Lyrica 150mg and Lyrica 50mg, and Percocet. Objective findings included; wearing a right knee brace; ambulates with a single crutch and limp, low back with decreased painful range of motion; right elbow and wrist with healed scar, tenderness, decreased range of motion. Treatment plan included pending authorization for ongoing pain management, pending multi-disciplinary evaluation, continued Lyrica, appeal Cymbalta, and wean from Ambien. At issue, is a request for authorization dated August 28, 2015 for Percocet and Prilosec. According to utilization review dated September 10, 2015 the request for Percocet 240 tablets 10-325mg was modified to Percocet 120 tablets 10-325mg. The request for Prilosec capsules 20mg #30 is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec capsules 20mg #30: 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): NSAIDs, GI symptoms & cardiovascular risk.

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 cardioprotection) 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, medical necessity cannot be affirmed. Therefore, the requested treatment is not medically necessary.

Percocet 10/325mg #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids, criteria for use, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

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 nonadherent) 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."Review of the available medical records reveals no documentation to support the medical necessity of Percocet nor any documentation addressing the '4 A's' domains, which is a recommended practice for the ongoing management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Furthermore, efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing this concern in the records available for my review. As MTUS recommends to discontinue opioids if there is no overall improvement in function, medical necessity cannot be affirmed.

Therefore, the requested treatment is not medically necessary.