

Case Number:	CM15-0208477		
Date Assigned:	10/27/2015	Date of Injury:	05/15/2009
Decision Date:	12/14/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	10/22/2015

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 55 year old male, who sustained an industrial injury on 5-15-09. The injured worker is diagnosed with lumbago, cervicgia, sciatica (right greater than left) and thoracic spine strain. The injured worker has permanent work restrictions. Notes dated 4-30-15, 6-30-15, 7-27-15, 8-27-15 and 9-25-15 reveals the injured worker presented with complaints of chronic neck, mid and low back pain. The back pain radiates to his lower extremities (left greater than right). Physical examinations dated 4-30-15, 6-30-15, 8-27-15 and 9-25-15 revealed diffuse tenderness in the cervical spine and painful range of motion; he is able to touch his chin to his chest. The thoracic and lumbar spine examination reveals left sided tenderness of the thoracic spine and the lumbar spine is diffusely tender. The midline incision is healed and tender; there is pain with range of motion. Treatment to date has included medications; Norco (3-2015), Soma (3-20015) and Omeprazole (3-2015), which provide pain and muscle spasm relief, (self-pay for his medications), back surgery, psychotherapy, lumbar epidural steroid injection provided pain relief per noted dated 6-30-15, lumbar laminectomy and partial facetectomy, hemilaminectomy and foraminotomy. Diagnostic studies include electrodiagnostic studies and lumbar MRI. A request for authorization dated 10-6-15 for Norco 10-325 mg #90-three times a day, Soma 350 mg #90-three times a day and Omeprazole 20 mg #60 is non-certified, per Utilization Review letter dated 10-13-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg #90 Three times a day: Upheld

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

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 norco nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going 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. The request is not medically necessary.

Soma 350 mg #90 Three times a day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Carisoprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Carisoprodol (Soma).

Decision rationale: Per MTUS CPMTG p29, "Not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs." With regard to medication history, the injured worker has been using this medication since at least 1/2015. However, as this medication is not recommended by MTUS, it is not medically necessary.

Omeprazole 20 mg mg # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

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 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)" Per the medical records, it was noted that the injured worker did have a history of gastritis with dyspepsia in 2005. However, the recent medical records do not note any GI symptoms. Furthermore, the injured worker is not presently on NSAID therapy. As the injured worker's risk for gastrointestinal events is low, medical necessity cannot be affirmed. The request is not medically necessary.