

Case Number:	CM15-0209103		
Date Assigned:	10/28/2015	Date of Injury:	02/25/1998
Decision Date:	12/14/2015	UR Denial Date:	10/12/2015
Priority:	Standard	Application Received:	10/23/2015

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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 53 year old female with a date of injury on 2-25-98. A review of the medical records indicates that the injured worker is undergoing treatment for chronic neck and back pain. Progress report dated 7-25-15 reports continued complaints of neck pain rated 7 out of 10. The symptoms are reported to be present 26 to 50 percent of the day and are described as aching and dull. She also has complaints of tension headaches. She has complaints of lower back pain rated 8 out of 10, which is present 100 percent of the day. The pain is described as sharp, throbbing, aching and numbness. The symptoms radiate down the left buttock, sore and pinching and down the left leg pinching constant and sharp. She has complaints of pelvic pain rated 8 out of 10. Chiropractic treatment done, immediate relief was reported and treatment tolerated well. Treatments include: medication, physical therapy, chiropractic therapy and multiple surgeries. Request for authorization dated 9-5-15 was made for Potassium chloride 10 meq, quantity 30. Utilization review dated 10-12-15 non-certified the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Potassium chloride 10meq, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM; Occupational Medicine Practice Guidelines; Evaluation and Management of Common Health Problems and Functional Recovery in Workers.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.uptodate.com/>; Clinical manifestations and treatment of hypokalemia in adults.

Decision rationale: MTUS and ACOEM are silent in regards to Potassium Chloride. Uptodate.com state: Uptodate summary and recommendations for Clinical manifestations and treatment of hypokalemia in adults: The most common causes of hypokalemia are gastrointestinal or urinary losses due to vomiting, diarrhea, or diuretic therapy. Hypokalemia may also result from the transient entry of potassium into cells, which is called redistributive hypokalemia. (See 'Introduction' above.) Manifestations of hypokalemia include severe muscle weakness, cardiac arrhythmias, renal abnormalities, and glucose intolerance. These signs and symptoms are generally proportionate to the degree and rapidity of the reduction in serum potassium and resolve with correction of the hypokalemia. The risk of arrhythmias from hypokalemia is highest in older patients, patients with organic heart disease, and patients on digoxin or anti-arrhythmic drugs. (See 'Manifestations of hypokalemia' above and 'General issues' above.) The underlying cause of the hypokalemia should be identified, particularly the presence of hypomagnesemia or redistributive hypokalemia. Patients with hypomagnesemia can be refractory to potassium replacement alone, and potassium replacement can result in rebound hyperkalemia in patients with redistributive hypokalemia. Among patients with redistributive hypokalemia due to increased sympathetic tone (as in hypokalemic thyrotoxic periodic paralysis), the administration of a nonselective beta blocker, such as propranolol, can rapidly reverse the hypokalemia and associated symptoms. (See 'Hypomagnesemia and redistributive hypokalemia' above and Thyrotoxic periodic paralysis, section on 'Acute treatment'.)- Oral potassium preparations include potassium chloride, potassium bicarbonate or its precursors (potassium citrate, potassium acetate), and potassium phosphate. Potassium chloride can be give in crystalline form (salt substitutes), as a liquid, or in a slow-release tablet or capsule. Potassium bicarbonate or its precursors is preferred in patients with hypokalemia and metabolic acidosis. Potassium phosphate should be considered only in patients with hypokalemia and hypophosphatemia, as might occur with proximal (type 2) renal tubular acidosis associated with Fanconi syndrome and phosphate wasting. (See 'Potassium preparations' above.) For patients with mild to moderate hypokalemia (serum potassium 3.0 to 3.4 meq/L) who do not have ongoing urinary potassium losses, we suggest initial oral administration of 10 to 20 meq of potassium given two to four times per day (20 to 80 meq/day) (Grade 2B). (See 'Mild to moderate hypokalemia' above.) Potassium therapy is less effective in patients who have chronic stable renal potassium wasting and are in a steady state, such as those on chronic diuretic therapy (at a fixed dose), or Gitelman or Bartter syndrome. In such patients, usual rates of potassium repletion produce only modest elevations in serum potassium. A potassium-sparing diuretic, such as amiloride is usually preferred in such patients. (See 'Ongoing losses and the steady state' above and "Pathophysiology and clinical features of primary aldosteronism", section on 'The steady state' and "General principles of disorders of water balance (hyponatremia and hypernatremia) and sodium balance (hypovolemia and edema)", section on 'The steady state'.) Patients with primary aldosteronism also present with hypokalemia due to renal

potassium wasting: spironolactone or eplerenone is preferred for such patients. (See "Pathophysiology and clinical features of primary aldosteronism", section on 'Cardiovascular risk' and "Treatment of primary aldosteronism".) If a potassium-sparing diuretic is used in combination with potassium supplements, we recommend close monitoring of potassium levels, along with dietary assessment and limitation of dietary potassium intake. This combination must be used with extreme caution in patients with decreased kidney function and in patients on an ACE inhibitor, renin inhibitor, and/or angiotensin receptor blocker. We suggest monitoring the serum potassium concentration approximately every three to four months in all patients receiving chronic potassium supplementation, or more often if clinically indicated.- Potassium must be given more rapidly to patients with hypokalemia that is severe (serum potassium less than 2.5 to 3.0 meq/L) or symptomatic (arrhythmias, marked muscle weakness, or rhabdomyolysis). In such patients, potassium chloride can be given orally in doses of 40 meq, three to four times per day or, particularly in patients also treated with intravenous potassium, 20 meq every two to three hours. (See 'Severe or symptomatic hypokalemia' above.)- For patients with severe manifestations of hypokalemia or those who are unable to take oral medications, we recommend intravenous potassium chloride (Grade 1B). (See 'Manifestations of hypokalemia' above and 'Intravenous therapy' above.) Depending upon the severity of symptoms, intravenous potassium may be given at doses ranging from 20 meq every two to three hours to a recommended maximum rate of potassium administration of 10 to 20 meq/hour for most patients; rates as high as 40meq/hour have been used for life-threatening hypokalemia. Rates above 20 meq/hour are highly irritating to peripheral veins. When such high rates are given, they should be infused into a large central vein or into multiple peripheral veins. The treating physician has not detailed the cause of the patient's hypokalemia or provided lab results showing low potassium. The rationale behind this request is unclear. As such, the request for Potassium chloride 10meq, #30 is not medically necessary.