

Case Number:	CM15-0027976		
Date Assigned:	03/30/2015	Date of Injury:	06/23/2011
Decision Date:	05/01/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/13/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 51 year old female who sustained an industrial injury on 06/23/2011. Diagnoses include thoracic/lumbosacral neuritis/radiculitis, cervicgia, and cervicocranial syndrome, spasm of muscle, lumbago, degenerative lumbar/lumbosacral intervertebral disc, and degenerative cervical intervertebral disc. Treatment to date has included diagnostics, medications, and work modification. A physician progress note dated 01/08/2015 documents the injured worker has continued neck, low back and bilateral leg pain, left greater than right. She has continued headaches with about 2 a week. Her worst pain is in the lumbar and thoracic spine area. Pain is rated at 6 out of 10 on the pain scale. There is decreased cervical and lumbar range of motion. Medications were discussed and recommendations were made. Treatment requested is for Duexis #90, and Percocet 10/325mg #150.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79-81. Decision based on Non-MTUS Citation ODG, Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids.

Decision rationale: Percocet (oxycodone with acetaminophen) is a short-acting opioid. Chronic pain guidelines and ODG do not recommend opioid "except for short use for severe cases, not to exceed 2 weeks" and "Routine long-term opioid therapy is not recommended, and ODG recommends consideration of a one-month limit on opioids for new chronic non-malignant pain patients in most cases, as there is little research to support use. The research available does not support overall general effectiveness and indicates numerous adverse effects with long-term use. The latter includes the risk of ongoing psychological dependence with difficulty weaning." Medical documents indicate that the patient has been on Percocet in excess of the recommended 2-week limit. Additionally, indications for when opioids should be discontinued include "If there is no overall improvement in function, unless there are extenuating circumstances." Medical records indicate that the overall pain level has increased over the last several months and there is lack of documentation of overall improvement in function, which are indications of when an opioid should be discontinued. As such, the request for PERCOCET 10/325MG #150 is not medically necessary.

Duexis #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk and Other Medical Treatment Guidelines Uptodate.com, NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity.

Decision rationale: MTUS Guidelines: Chronic Pain Medical Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk, page 68-69. Other Guidelines: Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk. Other Medical Treatment Guideline or Medical Evidence: Uptodate.com, NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity. After a professional and thorough review of the documents, my analysis is that the above listed issue: Is/was NOT medically necessary. My rationale for why the requested treatment/service is or is not medically necessary: Ranitidine is an H2 antagonist used for the treatment of stomach ulcers and gastroesophageal reflux. MTUS states, "Determine if the patient is at risk for gastrointestinal events: (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)." And "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)." Uptodate states regarding H2 antagonist for GI prophylaxis, "Standard doses of H2 receptor antagonists were not effective for the prevention of NSAID-induced gastric ulcers in most reports, although they may prevent duodenal ulcers [33]. Studies that detected a benefit on gastric ulcer prevention were short-term (12 to 24 weeks) and focused on endoscopic rather than clinical endpoints." The patient does not meet the age recommendations for increased GI risk. The medical documents provided establish the patient

has experienced GI discomfort, but is nonspecific and does not indicate history of peptic ulcer, GI bleeding or perforation. Medical records do not indicate that the patient is on ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID. Additionally, uptodate suggests that H2 antagonist at this dose is not useful for to prevent ulcers. As such, the request for Ranitidine 150mg is not medically necessary.