MAXIMUS Federal Services

Case Number:	CM15-0080945		
Date Assigned:	05/01/2015	Date of Injury:	04/26/2008
Decision Date:	06/05/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/27/2015

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: Pennsylvania
Certification(s)/Specialty: Internal 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 36 year old man sustained an industrial injury on 4/26/2008 due to a fall. Evaluations include a lumbar spine MRI from 2011. Diagnoses include lumbosacral disc disease, low back pain syndrome, thoracic or lumbosacral neuritis or radiculitis, esophageal reflux, myalgia and myositis, degeneration of lumbosacral intervertebral disc, and intervertebral disc disorder with myelopathy. Treatment has included oral medications, physical therapy, chiropractic treatment, home exercise program, and lumbar injections. MRI of the lumbar spine in December 2008 showed disc protrusions at L4-5 and L5-S1 without nerve root compression. Lumbar electrodiagnostic testing in 2010 was normal. The documentation submitted indicates that omeprazole has been prescribed since 2011 and that norco has been prescribed since 2012. Consultation with a gastroenterologist in 2011 was noted. The documentation from 1/15/15 notes that the injured worker had previously had a consultation with a spine surgeon, and that he would like to see another spine surgeon for a second opinion. Physician notes dated 3/16/2015 show complaints of continued unchanged low back pain rated 7/10 with medications and 10/10 without medications. A history of gastrointestinal (GI) upset from taking oral non-steroidal anti-inflammatory medications (NSAIDS) was noted and omeprazole was noted to help prevent that. Examination showed normal lower extremity strength and sensation, straight leg positive bilateral right greater than left, tenderness and muscle spasm over the paraspinal muscles, and increased pain with flexion. Lumbar MRI in 2011 was noted to show stable L4-5 degenerative disc disease and mild L4-5 spinal stenosis. Recommendations include orthopedic surgeon consultation, lumbar spine MRI, Norco, Naproxen, omeprazole and continue home exercise

program. The treating provider noted that the reason for lumbar MRI was because the MRI is over one year old and an updated MRI was requested. A signed opiate agreement was documented. Urine toxicology screening on 1/5/15 was noted to be consistent. Medications were noted to decrease pain and increase function, allowing the injured worker to move around and spend time with family. Work status was noted as disabled. On 3/30/15, Utilization Review (UR) non-certified or modified requests for the items currently under Independent Medical Review, citing the MTUS and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10mg 1-2 Q4-6 hours prn #180 6-week supply: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: This injured worker has been prescribed norco for more than two years. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. An opioid contract was noted and urine drug testing was discussed; however, there was no documentation of discussion of functional goals or return to work, and work status remains disabled. This injured worker has chronic back pain. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Specific improvement in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. As currently prescribed, norco does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Prilosec 20mg DR 1-2 QD #60 6-week supply: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs); NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation UpToDate: Medical management of gastroesophageal reflux disease in adults. In UpToDate, edited by Ted W. Post, published by UpToDate in Waltham, MA, 2015.

Decision rationale: This injured worker has been prescribed naproxen, a non-steroidal anti-inflammatory medication (NSAID), and prilosec, a proton pump inhibitor (PPI). Per the MTUS, co-therapy with a non-steroidal anti-inflammatory medication (NSAID) and a proton pump inhibitor (PPI) is not indicated in patients other than those at intermediate or high risk for gastrointestinal events (including age > 65 years, history of peptic ulcer, gastrointestinal (GI) bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant, or high dose/multiple NSAIDS such as NSAID plus low dose aspirin). None of these risk factors were present for this injured worker. Omeprazole (prilosec) has been prescribed for more than three years. Long term proton pump inhibitor (PPI) use (> 1 year) has been shown to increase the risk of hip fracture. The MTUS, FDA, and recent medical literature have described a significantly increased risk of hip, wrist, and spine fractures, pneumonia, Clostridium-difficile-associated diarrhea, and hypomagnesemia in patients on proton pump inhibitors. This injured worker was noted to have GI upset secondary to oral NSAIDS. If one were to presume that a medication were to be the cause of the GI upset, the treating physician would be expected to change the medication regime accordingly, at least on a trial basis to help determine causation. There was no documentation of gastroesophageal reflux. The UpToDate reference cited states that PPIs should be used for the treatment of reflux in patients who fail twice-daily histamine 2-receptor antagonist therapy, and in patients with erosive esophagitis and/or frequent (two or more episodes per week) or severe symptoms of GERD that impair quality of life. Due to lack of specific indication and potential for toxicity, the request for prilosec is not medically necessary.

Updated MRI lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section (updated 3/4/11).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter: MRI.

Decision rationale: The ACOEM guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient to warrant imaging in patients who do not respond to treatment and who would consider surgery as an option. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction, such as electromyography, should be obtained before ordering an imaging study. Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Computed tomography or MRI are recommended when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative. The ODG states that repeat MRI is indicated when there is significant change in symptoms and/or findings suggestive of significant pathology such as tumor, infection, fracture, neurocompression, or recurrent disc herniation. MRI of the lumbar spine is not indicated in light of the paucity of clinical findings suggesting any serious pathology; increased or ongoing pain, with or without radiation, is not in itself indication for MRI. There was no documentation of reinjury or worsening or symptoms or examination findings since the most recent MRI in 2011. Electrodiagnostic studies in 2010 were normal. Recent neurologic examination showed normal

lower extremity strength and sensation. No red flag conditions were noted. Due to lack of specific indication, the request for updated MRI of the lumbar spine is not medically necessary.

Surgical consult for low back: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The ACOEM states that referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair, and failure of conservative treatment to resolve disabling radicular symptoms. In this case there were no symptoms, physical examination findings, imaging studies, or electro-diagnostics consistent with radiculopathy. There are insufficient clinical findings of radiculopathy, such as dermatomal sensory loss or motor deficits correlating with a specific lesion identified by objective testing. A previous spine surgeon consultation was noted, without discussion of any change in clinical condition or findings. Due to lack of specific indication, the request for surgical consult for low back is not medically necessary.

Urine Toxicology Screening (Retrospective DOS 3/16/15): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines drug testing, opioids Page(s): 43, 77-78, 89, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: urine drug testing.

Decision rationale: This injured worker has been prescribed norco for over two years. Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. Ongoing monitoring is recommended if a patient has evidence of high risk of addiction and with certain clinical circumstances. Frequency of urine drug testing should be based on risk stratification. Patients with low risk of addiction/ aberrant behavior should be tested within six months of initiation of therapy and on a yearly

basis thereafter. Patients at moderate risk for addiction/aberrant behavior should be tested 2-3 times per year. Patients at high risk of adverse outcomes may require testing as often as once a month. Random collection is recommended. Results of testing should be documented and addressed. In this case, there was no documentation of risk assessment for aberrant behavior, which would be necessary to determine the interval of testing. A urine drug screen was performed in January 2015 and was consistent with prescribed medication. There was no documentation of moderate or high risk of addiction or aberrant behavior to warrant another urine drug screen in March of 2015. As such, the request for Urine Toxicology Screening (Retrospective DOS 3/16/15) is not medically necessary.