

Case Number:	CM14-0165724		
Date Assigned:	10/10/2014	Date of Injury:	07/07/2010
Decision Date:	11/05/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/08/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 41 year old male corrections officer with a date of injury of 07/07/2010. He was injured apprehending an inmate and sustained a low back injury. On 11/06/2013, on 12/10/2013 and on 02/27/2014 he was taking Percocet, Omeprazole and Ranitidine. He was not taking NSAIDS. On 05/15/2014 a lumbar MRI revealed a L4-L5 4 mm central disc protrusion and L5-S1 3mm disc bulge. On 07/07/2014 the low back pain was 4/10. On 07/23/2014 an electrodiagnostic study (EMG/NCS) was normal. He has been treated with medication, nerve blocks, epidural steroid injections, physical therapy, chiropractic care and a TENS unit. On 07/30/2104 he had low back pain with right sciatica. Right straight leg raise was positive. Lumbar range of motion was 75% of normal. On 09/24/2014 the low back pain was 4-5/10. He had a normal gait. Lumbar range of motion was decreased. Right straight leg raise was positive. He takes Ranitidine and omeprazole for GERD and gastritis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg, #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS , GI SYMPTOMS AND CARDIOVASCULAR RISK Page(s): 68.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 2014.Pain, Proton pump inhibitors.

Decision rationale: MTUS is silent about Omeprazole and Proton pump inhibitors except in the section on NSAIDS and GI bleeding. ODG also mentions proton pump inhibitors only in reference to bleeding and NSAIDS. This patient is not taking NSAIDS and has no increased risk of bleeding from NSAIDS. ODG notes that Proton Pump inhibitors are: "Recommended for patients at risk for gastrointestinal events. See NSAIDs, GI symptoms & cardiovascular risk. Prilosec (omeprazole), Prevacid (lansoprazole) and Nexium (esomeprazole magnesium) are PPIs. Omeprazole provides a statistically significantly greater acid control than lansoprazole. (Miner, 2010) Healing doses of PPIs are more effective than all other therapies, although there is an increase in overall adverse effects compared to placebo. Nexium and Prilosec are very similar molecules. For many people, Prilosec is more affordable than Nexium. Nexium is not available in a generic (as is Prilosec). Also, Prilosec is available as an over-the-counter product (Prilosec OTC), while Nexium is not. (Donnellan, 2010) In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Studies suggest, however, that nearly half of all PPI prescriptions are used for unapproved indications or no indications at all. Many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. If a PPI is used, omeprazole OTC (over the counter) tablets or lansoprazole 24HR OTC are recommended for an equivalent clinical efficacy and significant cost savings. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec), pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). (Shi, 2008) A trial of omeprazole or lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line. According to the latest AHRQ (Agency for Healthcare Research and Quality) Comparative Effectiveness Research, all of the commercially available PPIs appeared to be similarly effective. (AHRQ, 2011) However, this patient is not taking NSAIDS. He is not age 65 or higher and there is no documented increased risk of GI bleeding from opiates. Also, he is already taking Ranitidine. There is no objective documentation to substantiate that his patient requires Omeprazole in addition to Ranitidine.

Percocet 10/325mg, #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-going Management Page(s): 78-80.

Decision rationale: Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) Page 78 states in4) On-Going Management. Actions Should Include:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing

review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: 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 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. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The patient has remained off work and there is no documentation of any recent functional improvement. The documentation did not meet MTUS documentation criteria for continued Percocet on-going treatment and weaning was previously suggested.