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| Case Number: | CM15-0173476 | | |
| Date Assigned: | 09/15/2015 | Date of Injury: | 02/16/2005 |
| Decision Date: | 10/16/2015 | UR Denial Date: | 08/05/2015 |
| Priority: | Standard | Application Received: | 09/02/2015 |

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

Certification(s)/Specialty: Family Practice

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 43 year old male, who sustained an industrial injury on February 16, 2005. A review of the medical records indicates that the injured worker is undergoing treatment for status post removal of posterior hardware and revision decompression in November 2012, status post L4-L5 laminectomy-discectomy performed August 2006, degenerative disc disease at L5-S1 with persistent low back pain, left lower extremity radiculopathy, status post lumbar fusion and surgery November 2009, and right greater than left knee pain most likely secondary to altered gait. On July 23, 2015, the injured worker reported increased knee pain and swelling over the previous two weeks, with right greater than left knee swelling, low back pain that traveled down the bilateral legs, and weakness. The Treating Physician's report dated July 23, 2015, noted the injured worker had been utilizing over the counter Aleve, which had not helped with the pain or swelling. The injured worker was noted to have completed 12 out of 12 physical therapy visits with 50% decrease in symptoms and improvement in strength. A previous trial of acupuncture was noted to provide only minimal benefit. The injured worker was noted to have undergone lumbar surgeries, and cortisone injections to the bilateral knees. The injured worker's current medications were noted to include Norco for moderate to severe pain, Gabapentin for neuropathic pain, and Aciphex to counteract gastrointestinal (GI) symptoms caused by medications specifically over-the-counter (OTC) Aleve, with Laxacin prn. Previous-failed medication trials were noted to include Baclofen, Celebrex, Flexeril, Zanaflex, and KGLBC cream, Omeprazole, Cymbalta, and Tricyclic Antidepressants. On the visual analog scale (VAS) the injured worker rated his pain as 5-7 out of 10 with medication and 9-10 out of 10 without

medication. The injured worker reported 30-50% improvement in pain levels and up to 50% improvement in function with his current medication regimen. The injured worker was noted to have returned to work on a full time basis without restrictions with the medications, noting that without the medications the injured worker struggled to walk and stand. The injured worker was noted to have undergone a random urine drug screen (UDS) which demonstrated compliance with his prescribed medications. The treatment plan was noted to include continuation of the Norco, Aciphex, and Gabapentin, with a trial of Ibuprofen, and a random urine drug screen (UDS), having received modified certification for a random urine drug screen (UDS) two times per year. The documentation provided also included a urine drug screens dated January 23, 2015 and April 1, 2015, noted to be consistent with the prescribed medications. The Treating Physician's request for authorization included Gabapentin 600mg #60, Ibuprofen 600mg #60, Norco 10/325mg #90, a urine drug screen, and Aciphex 20mg #30. The Utilization Review (UR) dated August 5, 2015, certified the requests for Gabapentin 600mg #60, Ibuprofen 600mg #60, and Norco 10/325mg #90, and non-certified the requests for a urine drug screen and Aciphex 20mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aciphex 20mg #30: Upheld

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

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment guidelines comment on the use of proton pump inhibitors (PPIs), including Aciphex, in patients who are taking NSAIDs. In general, PPIs are used in patients who are determined to be at risk of a serious gastrointestinal (GI) side effect; including GI bleeding and ulcers. The specific recommendations are as follows: Clinicians should 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). 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 ug 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 cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. In this case, the records indicate that the patient is not at risk for a GI event. The patient is under age 60 and there is no history of a GI bleed, an ulcer

or perforation, or concurring use of an anticoagulant or high-dose multiple NSAIDs. For this reason, use of Aciphex is not medically necessary.

Urine drug screen: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Chronic Pain Section: Urine Drug Testing.

Decision rationale: The Official Disability Guidelines comment on the criteria for the use of urine drug testing. The specific criteria are as follows: 1. A point-of-contact (POC) immunoassay test is recommended prior to initiating chronic opioid therapy. This is not recommended in acute care situations (i.e. for treatment of nociceptive pain). There should be documentation of an addiction-screening test using a formal screening survey in the records prior to initiating treatment. If the test is appropriate, confirmatory lab testing is not required. 2. Frequency of urine drug testing should be based on documented evidence of risk stratification including use of a testing instrument. 3. Patients at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. In this case, the records indicate that the patient is at low risk for addiction and there is no documented evidence of aberrant/drug-seeking behavior. The patient had a documented urine drug screen on 7/23/2015 which was consistent with the medications prescribed. The progress notes state that there is no evidence of inappropriate use of opioids. For this reason, the frequency of testing is guided by the above-cited guidelines. Therefore, for this reason, a urine drug screen at this time is not medically necessary.