

<b>Case Number:</b>	CM15-0178008		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	01/02/2007
<b>Decision Date:</b>	10/21/2015	<b>UR Denial Date:</b>	08/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2015

### 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: North Carolina  
 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 59 year old female, who sustained an industrial injury on 1-2-07. The injured worker was diagnosed as having lumbosacral spine disc syndrome with strain-sprain disorder; radiculopathy; spinal stenosis with associated hypertension; lumbosacral spine disc syndrome with strain-sprain disorder, radiculopathy, facet syndrome, annular fissure; and placement of electric stimulation of the spine to reduce pain; thoracic spine strain-sprain disorder; chronic pain with idiopathic insomnia. Treatment to date has included physical therapy; status post decompression-dissection of thoracic spine cord with spinal cord stimulator placement (11-4-2013); urine drug screening; medications. Currently, the PR-2 notes dated 7-28-15 from the provider documents injured worker "had her spinal stimulator electrode and mechanism applied and went right from the first visit with the surgeon to having the full permanent electrode placed. Patient did not go through the temporary electrode placement. Patient now states the temporary was not explained to her. I do not know and I was not there. This is not my recommendation. Usually with this kind of electrode, people go through the temporary because they are not quite sure whether they want it or not. Since patient has had a permanent applied, patient has had one complaint after another. She recently saw [the surgeon] about this very topic and has a discussion with her about that." Objective findings are documented by this provider as: "1) reduced range of motion of the entire spine and in all segments thereof and in all planes thereof. 2) Reduced sensation and strength in the distribution of the left C6 and left S1 spinal nerve roots. 3) Absent left biceps and left ankle deep tendon reflexes. 4) Tender painful left paraspinal muscular spasms were noted in all three areas of the

spine. 5) Augmented touch floor gap and reduced bilateral straight leg raising measurements. 6) Posterior spine area in the lumbosacral spine area has become very painful and very spastic in the area of the insertion of the electrode". The injured worker is a status post bilateral T9 and T10 thoracic laminectomy for implantation of neurostimulator electrode, incision of subcutaneous placement of IPG spinal cord neurostimulator pulse generator, decompression and dissection of thoracic spine cord on 11- 4-2013. PR-2 notes back as far as 2-16-15 indicate the injured worker has been prescribed Percocet for neck and low back pain and Omeprazole 20mg #30 is not noted when this was first prescribed. Omeprazole has been prescribed A Request for Authorization is dated 9-8-15. A Utilization Review letter is dated 8-21-15 and non-certification was for Percocet 10/325mg PRN #120 and Omeprazole 20mg #30. Utilization Review denied the requested medications for not meeting the CA MTUS Guidelines. The provider is requesting authorization of Percocet 10/325mg PRN #120 and Omeprazole 20mg #30.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Percocet 10/325mg PRN #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: 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 non-adherent) 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 non-opioid 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. When to Continue Opioids: (a) If the patient has returned to work. (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documentation of significant subjective improvement in pain such as VAS scores. There is no objective measure of improvement in function or activities due to medication. Work status is not currently working. For these reasons all the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore, the request is not medically necessary.

**Omeprazole 20mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID therapy and proton pump inhibitors (PPI) states: Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. 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 a anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastro duodenal lesions. 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 µg 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. There is no documentation provided that places this patient at intermediate or high risk that would justify the use of a PPI. There is no mention of current gastrointestinal or cardiovascular disease. For these reasons, the criteria set forth above per the California MTUS for the use of this medication has not been met. Therefore, the request is not medically necessary.