

Case Number:	CM15-0178384		
Date Assigned:	09/18/2015	Date of Injury:	09/11/2014
Decision Date:	10/22/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	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:

This injured worker is a 51-year-old male who reported an industrial injury on 9-11-2014. His diagnoses, and or impressions, were noted to include: lumbar sprain-strain; lumbalgia-lumbar inter-vertebral disc without myelopathy; cervical neck sprain-strain; and thoracic sprain-strain. Recent electrodiagnostic studies of the lower extremities on 6-26-2015, noting abnormal findings; no current imaging studies were noted. His treatments were noted to include: medication management; and rest from work. The progress notes of 6-19-2015 reported a follow-up evaluation for complaints of: upper-mid-lower back pain; increased pain while working 8 hours per day, 40 hours per week, with constant sitting and standing, that was no longer working starting a few days before; intermittent but frequent neck and upper back pain that started at the head, with tightness, numbness and tingling, made worse by activities, and which occasionally radiated to the mid-low back and left upper and lower extremity and left #4 finger and left foot; and of frequent headaches in the back of the head, left > right, that occasionally radiated to the left temple. Objective findings were noted to include: a slight limp favoring the left side; mild, diffuse upper and mid back tenderness; moderate tenderness over the lumbosacral spine; and the review, and findings, of the 10-28-2014 magnetic resonance imaging studies of the lumbar and cervical spine and left shoulder. The physician's requests for treatments were noted to include the continuation-refills of: Percocet 10-325 mg, 1 tab twice a day as needed, #60, for severe cervical-thoracic-lumbar pain; and Omeprazole 20 mg, daily as needed. No Request for Authorization for Percocet 10-325 mg, 1 tab twice a day as needed, #60, for severe cervical-thoracic-lumbar pain; and Omeprazole 20 mg, daily as needed was not noted

in the medical records provided. The Utilization Review of 8-28-2015 non-certified the request for 60 tablets of Percocet 10-325 mg, and 60 capsules of Omeprazole 20 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Tablets of Percocet 10/325mg: Overturned

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 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. 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 documented significant decrease in objective pain measures such as VAS scores for significant periods of time. The patient is also working full time. Therefore, all criteria for the ongoing use of opioids have been met and the request is medically necessary.

60 Capsules of Omeprazole 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton pump inhibitors (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

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 riskfactors. 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 mg 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 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.