

Case Number:	CM15-0025349		
Date Assigned:	02/17/2015	Date of Injury:	09/12/2012
Decision Date:	04/14/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	02/10/2015

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: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 female who sustained an industrial injury on 09/12/2012. Diagnoses include right knee pain, status post right knee partial lateral meniscectomy and arthroscopic plica excision on 6/20/2013, severe degenerative joint disease of the right knee and compensatory left knee pain. Treatment to date has included medications, heat and ice, and applying compression. A physician progress note dated 12/20/2014 documents the injured worker has worsening right knee pain. Pain is rated as 10 out of 10 without medications, and 8 out of 10 with medications. Pain is described as aching. On examination, there is a small effusion and some mild swelling of the joint. It is tender at the medial and lateral aspect of the joint. Range of motion is full. There is crepitus on exam. She ambulates with an antalgic gait. A Magnetic Resonance Imaging done on 5/14/2014 on the right knee found prior anterior horn partial lateral meniscectomy, moderate osteoarthritis and no evidence of meniscal tear. Treatment requested is for Retrospective Norco 10/325mg #60 DOS: 12/1/14, and Retrospective Omeprazole 20mg #60 DOS: 12/01/14. On 01/15/2015 Utilization Review non-certified the request for Norco 10/325mg #60 DOS: 12/1/14, and cited was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines. The request for Omeprazole 20mg #60 DOS: 12/01/14, was non-certified and cited was California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Norco 10/325mg #60 DOS: 12/1/14: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 91.

Decision rationale: I respectfully disagree with the UR physician. Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding on-going management of opioids. 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 "4A's" (Analgesia, activities of daily living, adverse side effects, and any 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. The most recent progress note dated January 27, 2015 does indicate that there is an objective decrease in pain with the usage of Norco as well as increased ability to function, the absence of side effects as well as potential aberrant behavior. Considering this, this request for Norco 10/3 and 25 mg is medically necessary.

Retrospective Omeprazole 20mg #60 DOS: 12/1/14: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs, GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, & Cardiovascular Risk Page(s): 68-69.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (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). CPMTG guidelines further specify "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 g 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. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)"I respectfully disagree with UR physician. The most recent progress note dated January 27, 2015 does indicate that the injured employee does take omeprazole for G.I. upset and there is a concurrent prescription for naproxen. As such, this request for omeprazole is medically necessary.