

Case Number:	CM14-0155319		
Date Assigned:	09/25/2014	Date of Injury:	12/09/2005
Decision Date:	12/31/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/23/2014

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 Family 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:

This 46-year old mortgage broker reported injuries to her bilateral hands, wrists, elbows, shoulders and neck due to repetitive typing and writing, date of injury 12/9/05. Current diagnoses include cervical facet arthropathy, lumbar facet arthropathy, fibromyalgia, depression, Vitamin D deficiency, bilateral carpal tunnel syndrome, and status post bilateral carpal tunnel release. An 8/15/14 report from a pain specialist notes that the patient continues to complain of moderate to severe neck, low back and upper extremity pain. She reports functional limitations in the areas of self-care, activity, ambulation, hand function, and sleep. Exam findings include tenderness and limited range of motion of the neck, back and both shoulders. No blood pressure was recorded. Treatment plan included advising the patient to continue home exercise, and requesting authorization for acupuncture. The patient was advised to continue Duloxetine DR, Gabapentin, Tramadol, Vitamin D, Lansoprazole, Amitza, Metoprolol and Ferrous Sulfate. A rationale which states that the drug "is beneficial with intended effect at prescribed dose" is included for tramadol and Vitamin D. The provider notes that tramadol is recommended by the MTUS Guidelines for the treatment of chronic pain and of neuropathic pain. There is a notation that the patient's 25(OH) Vitamin D level was 16 on 12/20/13. The provider states that Vitamin D deficiency is common in patients with chronic pain syndromes, and that treatment with Vitamin D supplementation may improve their symptoms. The only rationale for lansoprazole and metoprolol states "renew as previously prescribed". All of four of these medications were non-certified in UR on 8/27/14. The patient's work status is deferred to her primary treater. There are several other similar notes from the pain specialist in the available records, ranging from April 2014 to August 2014. All describe similar complaints and identical functional limitations. The patient's medications remain the same. The patient's blood pressure is never documented. There is a 3/2/14 rheumatology Qualified Medical Examiner (QME) report, which

notes that the patient has had well-controlled hypertension since about 2011. He also notes that the patient is permanently totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol Hydrochloride 50mg, 90 tablets: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Criteria for use of Opioids, Opioids for neuropathic pain Page.

Decision rationale: Tramadol is an opioid medication and therefore falls under guidelines for medications in general and for opioids specifically. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. The clinical findings in this case do not demonstrate that any of the above criteria have been met. There is no documentation that tramadol was introduced individually, with ongoing careful assessment of function. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. Many of the documented symptoms as well as treatments (Gabapentin and Duloxetine) make it appear that the patient's pain is neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was documented of whether or not opioid use was likely to be helpful in this patient. No specific functional goals were set or followed. Most importantly, tramadol was not discontinued when it became clear that it has not produced any functional improvement. This patient remains totally disabled, and challenged by daily activities such as personal care. This is more than adequate evidence that this patient is not responding appropriately to Tramadol, and that it should be discontinued. The request for Tramadol Hydrochloride 50mg, 90 tablets is not medically necessary.

Vitamin D-3 (2000 Units) 60 tablets: 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 Other Medical Treatment Guideline or Medical Evidence: UptoDate, an online, evidence-based review service for clinicians (www.uptodate.com), Vitamin D deficiency in adults: Definition, clinical manifestations, and treatment.

Decision rationale: The UptoDate reference cited above states that the optimal serum 25(OH) D concentration for skeletal health is controversial, with some experts recommending maintaining levels between 20 and 40, and others between 30 and 50. This patient's 25(OH) D level was 16 on 3/21/14, and she has been taking Vitamin D supplements ever since. However, the records available to me contain a 3/14/14 25(OH) D level of 38.5, which is well within the normal range and is actually approaching high according to some experts. She has clearly not had any reduction in pain levels or increase in function as a result of taking Vitamin D for months. Based on the evidence-based citation above and on the clinical information provided for my review, Vitamin D-3 2000 units #60 is not medically necessary, because the patient no longer has a Vitamin D deficiency and she did not show any improvement in pain or function as a result of taking Vitamin D for months.

Lanzoprazole 30mg, 30 tablets: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, an evidence-based online review service for clinicians, (www.uptodate.com), Lansoprazole: drug information

Decision rationale: Lansoprazole is a proton pump inhibitor, or PPI. The first guideline cited above states that clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. They should determine if the patient is at risk for GI events. Risk factors include age over 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of aspirin, corticosteroids, or an anticoagulant; or high-dose or multiple NSAIDs, or an NSAID combined with aspirin. Patients with no GI risk factors and no cardiovascular disease may be prescribed a non-selective NSAID. Those at intermediate risk for GI disease should receive a non-selective NSAID plus a proton pump inhibitor (PPI) or misoprostol; or a Cox-2 selective NSAID. Patients at high GI risk should receive a Cox-2 selective NSAID and a PPI if an NSAID is absolutely necessary. This reference notes that long-term PPI use has been shown to increase the risk of hip fracture. The UptoDate reference cited above lists the indications for lansoprazole as active duodenal ulcer, gastric ulcer, erosive esophagitis, helicobacter pylori eradication, pathological hypersecretory conditions (such as Zollinger-Ellison syndrome), frequent heartburn, GERD or other acid-related disorders, NSAID-induced ulcer treatment, NSAID-induced ulcer prophylaxis, and stress ulcer prophylaxis in ICU patients. Risks of long-term (usually over one year) use include atrophic gastritis, increased incidence of gastric carcinoid tumors, clostridium difficile-associated diarrhea, increased incidence of osteoporosis-

related fractures of the hip, spine, or wrist; hypomagnesemia and Vitamin B12 deficiency. It is impossible to guess from the available clinical records why lansoprazole is being prescribed for this patient. There is no documentation of her risk for GI events. There is no documentation of any condition likely to require a PPI prescription, or of any symptoms suggestive of such a condition. The patient is not taking an NSAID. It does appear likely that the patient has been taking lansoprazole for at least a year, which would put her at risk for the side effects listed above, many of which could be life threatening. Based on the evidence-based references cited above and the available clinical information, Lansoprazole is not medically necessary because there is no documentation of any benefit to the patient that is likely to outweigh its risks.

Metoprolol 25mg, 90 tablets: 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 Other Medical Treatment Guideline or Medical Evidence: UptoDate, an evidence-based online review service for clinicians, (www.uptodate.com), Metoprolol, drug information

Decision rationale: According to the UptoDate reference above, metoprolol is a beta-blocker that is used for hypertension, angina, atrial fibrillation, heart failure and myocardial infarction. If metoprolol is being used for hypertension, it should be started in patients under 60 who have a systolic blood pressure over 140 or diastolic BP of over 90. The goal of therapy is to maintain systolic BP less than 140 and diastolic BP less than 90. The clinical documentation in this case does not support the ongoing prescription of metoprolol. The notes do not contain any documentation about why this secondary treater, who is a pain specialist, is dispensing it. The rheumatologic QME noted that the patient has a history of hypertension, and also noted that the patient has a primary provider to whom he was planning to refer the patient for her lipid issues. If in fact metoprolol were being prescribed for hypertension, the primary treater would be the obvious choice for monitoring its effects and changing dosage or adding medications as needed. Since the secondary treater in this case does not even check the patient's blood pressure, he cannot be monitoring this medication appropriately and he should not be dispensing it. Based on the evidence-based citation above and the clinical information provided for my review, Metoprolol 25 mg #90 is not medically necessary.