

Case Number:	CM14-0188161		
Date Assigned:	11/18/2014	Date of Injury:	01/25/2010
Decision Date:	01/07/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/12/2014

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 Ohio. 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:

The injured worker is a 51-year-old female with a date of injury of January 25, 2010. Evidently there been other injuries, more for cumulative nature, involving the neck, back, shoulders, arms, and elbows. Presently she complains primarily of low back pain, headaches pain, weakness, and numbness of the left index finger and thumb. On January 6, 2011 she had surgical release of the A1 pulley system. She has taken a variety of medications over the last 4 years including Norco 10/325 mg, tramadol ER 100 and 150 mg, naproxen 550 mg twice daily to 3 times daily, and Nalfon for her milligrams twice daily. It has previously been reported that with Norco for pain levels diminish from a baseline of 6-7/10 to 4-5/10 allowing her to be functional and mobile. She has a history of abdominal discomfort, presumed to be gastritis, from Naprosyn. She is not working. She has recently had trazodone and Effexor added to her medications. The diagnoses include lumbar strain/sprain with radicular symptoms, myofascial pain with sleep disturbance, lumbar facet disease, cervical radiculopathy, created lumbar discs, depression, anxiety, somatoform disorder, left cubital tunnel syndrome, wrist joint inflammation, and stenosing tenosynovitis of the index finger and thumb.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94, 113..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Tramadol (Ultram ; Ultram ER ; generic available in immediate release tablet): Tramadol is a synthetic opioid affecting the central nervous system. Side Effects: Dizziness, nausea, constipation, headache, somnolence, flushing, pruritus, vomiting, insomnia, dry mouth, and diarrhea. Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. Do not prescribe to patients that at risk for suicide or addiction. Warning: Tramadol may produce life-threatening serotonin syndrome, in particular when used concomitantly with SSRIs, SNRIs, TCAs, and MAOIs, and triptans or other drugs that may impair serotonin metabolism. Analgesic dose: Tramadol is indicated for moderate to severe pain. The immediate release formulation is recommended at a dose of 50 to 100mg PO every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 to 6 hours (max 400mg/day). Ultram ER: Patient currently not on immediate release tramadol should be started at a dose of 100mg once daily. The dose should be titrated upwards by 100mg increments if needed (Max dose 300mg/day). Tramadol is grouped with the other opioids in the Chronic Pain Medical Treatment Guidelines. Those requiring opioids chronically should have ongoing assessment for pain relief, functionality, adverse side effects, and any aberrant drug taking behavior. Opioids may be continued if there is improved pain and functionality as a consequence or when the injured worker has regained employment. In this instance, there is no documentation that monitoring for aberrant drug taking behavior is occurring. For example there is no reference to urine drug screening. Similarly, the documentation provided does not mention a signed pain contract agreement on file. The reviewed records do show pain relief with Norco but nothing is specified in terms of tramadol. The combination of tramadol and antidepressants such as Effexor create the possibility for the serotonin syndrome. Consequently, because the basic requirements for opioid prescribing have not been satisfied with respect to tramadol, and because of the possibility of a dangerous drug interaction, the request for Tramadol ER 150 mg is not medically necessary.

Protonix 20 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and Cardiovascular Risk Page(s): 69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Proton Pump Inhibitors.

Decision rationale: For the treatment of dyspepsia secondary to NSAID therapy the options include stopping the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Studies suggest,

however, that nearly half of all PPI prescriptions are used for unapproved indications or no indications at all. Many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. If a PPI is used, omeprazole OTC tablets or lansoprazole 24HR OTC are recommended for an equivalent clinical efficacy and significant cost savings. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec), pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). (Shi, 2008) A trial of omeprazole or lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line. In this instance, the injured worker does have a history of abdominal complaints and suspected gastritis as a consequence of NSAID therapy. The documentation provided, however, does not provide rationale as to why the recommended first-line medications omeprazole or lansoprazole would not be appropriate. Consequently, the request for Protonix 20 mg is not medically necessary.