

Case Number:	CM14-0194282		
Date Assigned:	12/02/2014	Date of Injury:	02/02/2013
Decision Date:	01/31/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/20/2014

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 Practice 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:

The injured worker is a forty-four year old female who sustained a work-related injury on February 2, 2013. A request for retrospective pantoprazole 20 mg #60 and retrospective tramadol HCl ER 150 mg #45 was non-certified by Utilization Review (UR) on October 28, 2014. The UR physician utilized California (CA) MTUS guidelines when evaluation this request. With respect for pantoprazole, the CA MTUS guidelines recommend this medication for patients with complaints of gastritis, GERD or dyspepsia. Prophylactic use of drugs such as pantoprazole is supported by CA MTUS when the injured worker is greater than 65 years of age, has a history of peptic ulcer, GI bleeding or perforation, has concurrent use of aspirin, corticosteroids and/or an anticoagulant or when high dose/multiple NSAIDs are used. Upon review of the documentation submitted for review the UR physician determined that the injured worker did not meet the recommended criteria for use of pantoprazole. With regard to the request for tramadol, CA MTUS guidelines require medical documentation to provide ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects of patients undergoing pain medication therapy. The UR physician determined that the documentation submitted for review did not included documentation of subjective or objective benefit from the use of tramadol. A request for independent medical review was initiated on November 20, 2014. A review of the medical documentation submitted for independent medical review included imaging reports conducted on January 30, 2014 as follows: An MRI of the right elbow revealed lateral epicondylitis; an MRI of the right wrist revealed carpal tunnel syndrome and subchondral cyst formation; and an MRI of the right shoulder revealed supratendinitis and intraspinus tendonitis. Documentation of February 7, 2014 revealed that the injured worker had received chirotherapy which was documented as not helping; On February 17, 2014 an EMG/NCS was conducted which revealed mild to moderate bilateral carpal tunnel syndrome.

The evaluation provider prescribed Tramadol ER HCl 150 mg #45 and pantoprazole sodium DR 20 mg #60 for therapy. A physician's report dated May 19, 2014 revealed that the injured worker complained of constant burning and aching in the right wrist with radiation to the right elbow and shoulder. She rated the pain a 6 on a 10-point scale. She reported pain of the left wrist with radiation to the left elbow and shoulder and rated this pain a 4 on a 10-point scale. The documentation submitted for review did not include evidence of functional improvements in activities of daily living as related to the use of Tramadol. In addition, the documentation did not reveal evidence of gastrointestinal issues including a history of peptic ulcer, gastrointestinal bleeding or perforation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Pantoprazole 20mg #60: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines comment on the use of proton pump inhibitors (PPIs) such as pantoprazole as an adjunct when a patient is on an NSAID. These guidelines state that use of PPIs is guided by their risk for a gastrointestinal event. Specifically, the guidelines state the following: 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 an 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 gastroduodenal 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 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. In this case, there is no documentation to indicate that the patient was having symptoms of gastritis prior to the use of the PPI. Further, there is no evidence that the patient meets the MTUS criteria for being at intermediate or high-risk for a gastrointestinal event. Under these conditions, the use of Pantoprazole is not considered medically necessary.

Retrospective: Tramadol HCL ER 150mg #45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids. These guidelines have established criteria on the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an 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. There should be evidence of documentation of the "4 A's for Ongoing Monitoring." These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be 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 that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. There is insufficient documentation of the "4 A's for Ongoing Monitoring." The treatment course of opioids in this patient has extended well beyond the timeframe required for a reassessment of therapy. There is no evidence of benefit in either functional capacity or pain control. In summary, there is insufficient documentation to support the chronic use of an opioid in this patient. Therefore, this request is not medically necessary.