

Case Number:	CM15-0134696		
Date Assigned:	07/23/2015	Date of Injury:	05/10/2011
Decision Date:	09/17/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/13/2015

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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 36 year old female, who sustained an industrial injury on 5/10/2011. The mechanism of injury is unknown. The injured worker was diagnosed as having complex regional pain syndrome. There is no record of a recent diagnostic study. Treatment to date has included right hand ganglion cyst removal, stellate ganglion blocks, physical therapy and medication management. In a progress note dated 5/20/2015, the injured worker complains of right hand pain and swelling. Physical examination showed right hand tenderness and diffuse left upper extremity pain. The injured worker was hospitalized for nausea and vomiting and was discharged on 6/16/2015 with multiple prescriptions. The treating physician is requesting Carafate 1g/10 ml #280, Oxycodone Hcl 5 mg #60, Ondansetron Hcl 4 mg #60, Lisinopril 5 mg #30 and Lorazepam .05 mg #20.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carafate 1 g/10 ml Qty 280: 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: www.uptodate.com, Pharmacology of antiulcer medications.

Decision rationale: MTUS is silent specifically with regards to Carafate. Uptodate states, "Sucralfate (Carafate) is a sulfated polysaccharide, sucrose octasulfate, complexed with aluminum hydroxide. It prevents acute chemically-induced mucosal damage and heals chronic ulcers without altering gastric acid or pepsin secretion or significantly buffering acid [33, 38]. Similar to aluminum-containing antacids, sucralfate stimulates angiogenesis and the formation of granulation tissue, possibly due to growth factor binding [33]. Sucralfate also binds to the injured tissue, thereby delivering growth factors and reducing access to pepsin and acid." Medical records do not substantiate acute chemically-induced mucosal damage or chronic ulcers. Given the lack of substantiating information, the request cannot be approved at this time. As such, the request for Carafate is not medically necessary at this time.

Oxycodone HCL (hydrochloride) 5 mg Qty 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) and Pain, Opioids.

Decision rationale: Oxycodone is the generic version of Oxycontin, which is a pure opioid agonist. ODG does not recommend the use of opioids for low back pain except for short use for severe cases, not to exceed 2 weeks. The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "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." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the request is not medically necessary.

Ondansetron HCL (hydrochloride) 4 mg Qty 60: 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 Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Anti-emetics (for opioid nausea).

Decision rationale: Ondansetron (Zofran) is an anti-emetic used to decrease nausea and vomiting. Nausea is a known side effect of chronic opioid use and some Serotonin norepinephrine reuptake inhibitors (SNRIs). ODG does not recommend use of anti-emetic for nausea and vomiting secondary to chronic opioid use. Additionally, "This drug is a serotonin 5-HT₃ receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use." There is no evidence that patient is undergoing chemotherapy/radiation treatment or postoperative. MTUS is specific regarding the gastrointestinal symptoms related to NSAID usage. If criteria are met, the first line treatment is to discontinue usage of NSAID, switch NSAID, or consider usage of proton pump inhibitor. There is no documentation provided that indicated the discontinuation of NSAID or switching of NSAID occurred. Additionally, Ondansetron is not a proton pump inhibitor and is not considered first line treatment. As such the request is not medically necessary.

Lisinopril 5 mg Qty 30: 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 Official Disability Guidelines (ODG) Diabetes (Type 1, 2, and Gestational), Hypertension treatment.

Decision rationale: MTUS is silent specifically with regards to lisinopril. Therefore, other guidelines were utilized. ODG states regarding the treatment of hypertension: After Lifestyle (diet & exercise) modifications: (1) First line, 1st choice, Renin-angiotensin-aldosterone system blockers: ACE inhibitors (angiotensin-converting enzyme inhibitor): Benazepril (Lotensin); Captopril (Capoten); Enalapril (Vasotec); Lisinopril (Zestril); Ramipril (Altace), Angiotensin II receptor blocker (ARBs): Losartan (Cozaar); Olmesartan (Benicar); Valsartan (Diovan); (2) First line, 2nd addition, Calcium channel blockers: Amlodipine (Norvasc); Nifedipine (Procardia); (3) First line, 3rd addition, Thiazide diuretic, Hydrochlorothiazide (HCTZ); (4) First line, 4th addition, Beta blockers (b-Adrenergic blocker): Atenolol (Tenormin); Metoprolol (Lopressor); Nadolol (Corgard); Propranolol (Inderal); (5) Second line: Aldosterone receptor blockers: Spironolactone (Aldactone), Direct renin inhibitor: Aliskiren (Tekturna) Selective α₁-adrenergic blockers: Doxazosin (Cardura); Prazosin (Minipress); Terazosin (Hytrin), Central α₂ agonists: Clonidine (Catapres), Direct vasodilators: Hydralazine (Apresoline); Minoxidil (Loniten). While lisinopril is an appropriate first line medication for hypertension, medical documents do not substantiate the diagnosis of hypertension. The medical notes provided did not have blood pressure readings. As such, the request for Lisinopril 5mg #30 is not medically necessary.

Lorazepam 0.5 mg Qty 20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines: Insomnia treatment-Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness, Benzodiazepines.

Decision rationale: MTUS and ODG states that benzodiazepine (ie Lorazepam) is "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks." ODG further states regarding Lorazepam not recommended. The requested quantity is in excess of the guidelines. Therefore, the request is not medically necessary.