

Case Number:	CM15-0057961		
Date Assigned:	04/02/2015	Date of Injury:	05/09/2012
Decision Date:	06/12/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	03/26/2015

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: Arizona, Michigan

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 57-year-old male, who sustained an industrial injury on 5/9/2012. The current diagnoses are cervicalgia, lumbosacral neuritis, and carpal tunnel syndrome. According to the progress report dated 2/10/2015, the injured worker complains of constant sharp pain in the cervical spine that is aggravated by repetitive motion of the neck, pushing, pulling, lifting, forward reaching, and working at or above the shoulder level. There is radiation of pain into the upper extremities. There are associated headaches that are migrainous in nature as well as tension between the shoulder blades. He has constant, sharp pain in the low back that radiates into the bilateral lower extremities. He reports constant sharp pain in the right wrist/hand. The pain is rated 8/10 on a subjective pain scale. The current medications are Naprosyn and Tramadol. Treatment to date has included medication management, cervical epidural steroid injection (very helpful), MRI's, electro diagnostic studies, home exercise program, and lumbar epidural steroid injection. The plan of care includes Omeprazole, Ondansetron, Cyclobenzaprine, Tramadol, and Fenoprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #120: 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 and cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)/Proton Pump Inhibitors (PPIs).

Decision rationale: Per the MTUS, Clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors according to specific criteria listed in the MTUS and a selection should be made based on these criteria 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). Per the ODG, PPI's are recommended for patients at risk for gastrointestinal events. Prilosec (omeprazole), Prevacid (lansoprazole) and Nexium (esomeprazole magnesium) are PPIs. Healing doses of PPIs are more effective than all other therapies, although there is an increase in overall adverse effects compared to placebo. Nexium and Prilosec are very similar molecules. In this RCT, omeprazole provided a statistically significantly greater acid control than lansoprazole. 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. 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 had been recommended before prescription Nexium therapy (before it went OTC). The other PPIs, Protonix, Dexilant, and Aciphex, should be second-line. According to the latest AHRQ Comparative Effectiveness Research, all of the commercially available PPIs appeared to be similarly effective. A review of the injured workers medical records that are available to me do not reveal any gastrointestinal complaints or history that would suggest that the injured worker is at increased risk for a gastrointestinal event, therefore the request is not medically necessary.

Ondansetron 8mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 02/23/15).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Antiemetics (for opioid nausea)/Ondansetron/Zofran.

Decision rationale: The MTUS/ ACOEM did not specifically address the use of ondansetron in the injured worker therefore, other guidelines were consulted. Per the ODG, ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Recommended for acute use as noted below per FDA-approved indications. Nausea and vomiting is common with use of

opioids. These side effects tend to diminish over days to weeks of continued exposure. Studies of opioid adverse effects including nausea and vomiting are limited to short-term duration (less than four weeks) and have limited application to long-term use. If nausea and vomiting remains prolonged, other etiologies of these symptoms should be evaluated for. The differential diagnosis includes gastroparesis (primarily due to diabetes). Current research for treatment of nausea and vomiting as related to opioid use primarily addresses the use of antiemetics in patients with cancer pain or those utilizing opioids for acute/postoperative therapy. Recommendations based on these studies cannot be extrapolated to chronic non-malignant pain patients. There is no high- quality literature to support any one treatment for opioid-induced nausea in chronic non- malignant pain patients. (Moore 2005) Ondansetron (Zofran): 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. Acute use is FDA-approved for gastroenteritis. A review of the injured workers medical records reveals that ondansetron is being prescribed for the treatment of opioid induced nausea and based on the guidelines is not medically necessary.

Cyclobenzaprine Hydrochloride 7.5mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: Per the MTUS, Cyclobenzaprine is recommended as an option in the treatment of chronic pain using a short course of therapy. It is more effective than placebo in the management of back pain, the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment suggesting that shorter courses may be better. Treatment should be brief. A review of the injured workers medical records reveal that he has been on cyclobenzaprine long term, which is not consistent with the guideline recommendations. Therefore, the request for Cyclobenzaprine Hydrochloride 7.5mg #120 is not medically necessary.

Tramadol ER 150mg #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol (Ultram) Page(s): 74-96, 113.

Decision rationale: The MTUS states that tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Opioids are recommended for chronic pain, especially neuropathic pain that has not responded to first line recommendations like antidepressants and anticonvulsants. Long terms users should be reassessed per specific guideline recommendations and the dose should not be lowered if it is working. Per the MTUS,

Tramadol is indicated for moderate to severe pain. A review of the injured workers medical records reveal documentation of pain and functional improvement with the use of tramadol and the continued use of Tramadol ER 150mg #90 is medically necessary.