

Case Number:	CM13-0036276		
Date Assigned:	12/13/2013	Date of Injury:	07/22/2009
Decision Date:	01/30/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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 46 year old patient reported an industrial injury on 7/22/2009, The QME evaluation dated 2/20/2011 by [REDACTED] dated 2/10/2011 documented a comprehensive physical examination and history. The diagnoses included crush injury to left hand, with residual chronic flexion/contracture of the left hip anger with limitation to range of motion; sprain/strain of the left knee aggravating underlying arthritis; nonindustrial arthritis of the right hip secondary to congenital hip pathology; lumbosacral sprain/strain most likely secondary to right hip pathology. The patient was assessed as having industrial injury to the left hand and left knee. The recommendations for future medical care included "viscosupplementation such as Synvisc once or twice a year to try to reduce inflammatory component of the left knee; knee exercises; bike exercises were good for the knee and hip; NSAIDs; possible repeated diagnostic study; may require total knee replacement; no further surgical intervention to the left hand; NSAIDs recommended along with protective medications such as H2- blockers are proton pump inhibitors". Most recent medical record dated 8/30/2013 by [REDACTED] reported patient having symptoms to the knee; pain to the back, and headaches. The objective findings on examination included findings related to the back and hand; left hip with TTP and decreased ROM. The left knee was noted "well healed scars; brace in place; diffuse TTP; quadriceps atrophy; lateral joint line tenderness; orthopedic testing negative; flexion 135 degrees; extension 0 degrees. The diagnoses included status post left knee arthroscopy; left knee degenerative joint disease; contracture left small finger; left hip greater trochanteric bursitis; HNP lumbar spine; lumbar radiculopathy; and headaches. The treatment plan included x-rays of the knee; Diclofenac XR 100 mg; Tramadol ER 150 mg for chronic pain; and omeprazole 20 mg to reduce NSAID gastritis. X -rays documented arthrosis of the

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID, GI Symptoms and Cardiovascular disease Page(s): 68.

Decision rationale: The Physician Reviewer's decision rationale: Omeperazole is a proton-pump inhibitor (PPI) which can be used as a co-treatment of patients on NSAID therapy who at risk of gastro-intestinal bleeding. CA-MTUS(Effective July 18 2009) Guidelines recommend determining first the risk factors for gastrointestinal events and cardiovascular disease. When a patient is at a low risk for gastrointestinal event and cardiovascular disease, a full-dose naproxen is the preferred choice of NSAID medication. GI prophylaxis is indicated in patients with history of peptic ulcer, GI bleed perforation, patients above 65-years of age, patients prescribed aspirin, steroids, anticoagulants and NSAIDs either single or in multiple doses. If and when naproxen is ineffective, the addition of an aspirin. and a PPI is an option. A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 $\hat{1}$ /₄g 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).According to medical records, the patient did not have a history of gastrointestinal issues, and additionally, the patient was not concurrently prescribed aspirin, corticosteroids, anticoagulants, or a high dose of NSAIDs that have caused an adverse reaction in the past. Taking into consideration the above discussion, the retrospective request for Omeprazole 20mg, #60: is not medically necessary.

Tamadol ER 150mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75, 80 and 84.

Decision rationale: The Physician Reviewer's decision rationale: MTUS (Effective July 18, 2009) Chronic Pain Medical Treatment Guidelines (pages 75, 80 and 84), Tramadol (Ultram)-classified as a small class of synthetic opioids, with opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine as a Central acting analgesics. This class of synthetic opioids has been reported to be effective in managing neuropathic pain, with side effects similar to traditional opioids. "Opioids efficacy is limited to short term pain relief, and long term efficacy is unclear". Failure to respond to a time-limited course of opioids has led to suggestion of reassessment and consideration of alternative therapy. A recent Cochrane

review found that Ultram decreased pain intensity, produced symptom relief and improved function for a time period of up to three months but the benefits were small (a 12% decrease in pain intensity from baseline). Adverse events often caused study participants to discontinue this medication, and could limit usefulness. There are three studies comparing Tramadol to placebo that have reported pain relief, but this increase did not necessarily improve function. (Deshpande, 2007) . Short-term use: Recommended on a trial basis for short-term use after there has been evidence of failure of first-line non-pharmacologic and medication options (such as acetaminophen or NSAIDs) and when there is evidence of moderate to severe pain. Also recommended for a trial if there is evidence of contraindications for use of first-line medications. Weak opioids should be considered at initiation of treatment with this class of drugs (such as Tramadol, Tramadol/acetaminophen, hydrocodone and codeine), and stronger opioids are only recommended for treatment of severe pain under exceptional circumstances (oxymorphone, oxycodone, hydromorphone, fentanyl, morphine sulfate). Benefits of opioids are limited by frequent side effects (including nausea, constipation, dizziness, and somnolence and vomiting). (Stitik, 2006) (Avouac, 2007) (Zhang, 2008). Opioids are not recommended as a first line therapy for osteoarthritis, and there is no documentation that the first line therapy has failed. Therefore the request for Tamadol ER 150mg, #30 was not medically necessary.