

Case Number:	CM14-0146932		
Date Assigned:	09/12/2014	Date of Injury:	04/22/2009
Decision Date:	10/15/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/10/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine 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 42-year-old female with an initial date of injury of April 22, 2009. The injured worker has chronic shoulder pain due to acromioclavicular (AC) joint arthritis, bicycle tendinitis, and rotator cuff syndrome. The patient underwent right shoulder arthroscopic synovectomy, bursectomy, distal clavicle excision, and acromioplasty on June 21, 2012. Additional affected body regions include the right knee, right wrist, and right elbow. The injured worker had previously been on long-term non-steroidal anti-inflammatory drug (NSAID) use, and developed gastrointestinal upset. As a result, a proton pump inhibitor in the form of Protonix was started. The disputed issue is a request for Protonix 10 mg number 60. This was denied by a utilization review on date of service August 26, 2014. It was noted by the utilization reviewer that the patient had stopped taking naproxen. A recent progress note available for review is dated August 12, 2014, and notes that the patient is on Ultracet, tramadol extended release, gabapentin, Norflex, and Protonix.

IMR ISSUES, DECISIONS AND RATIONALES

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

Protonix 20mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPI Section, Page(s): 68-69.

Decision rationale: The Chronic Pain Medical Treatment Guidelines on page 68-69 states the following regarding the usage of proton pump inhibitors (PPI): "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 (200g 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. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" A recent progress note dated August 12, 2014 notes that the patient is on Ultracet, tramadol extended release, gabapentin, Norflex, and Protonix. The patient is no longer on any non-steroidal anti-inflammatory drugs, but is still documented as having upset stomach. The CA-MTUS provides guidance with regard to which patients on NSAID medication should have a proton pump inhibitor, but there can be indications for proton pump inhibitors in patients that do not take NSAIDs. Examples of this include patients with gastroesophageal reflux, gastric ulcer, or medication intolerance to other agents that the patient is being prescribed. It is appropriate to continue a proton pump inhibitor for a short duration for symptomatic management.

Protonix 10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPI and NSAIDs Page(s): 68-69. Decision based on Non-MTUS Citation Uptodate Online, Protonix entry

Decision rationale: The Chronic Pain Medical Treatment Guidelines on page 68-69 states the following regarding the usage of proton pump inhibitors (PPI): "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. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)"

A recent progress note available for review is dated August 12, 2014, and documents that the patient is on Ultracet, tramadol extended release, gabapentin, Norflex, and Protonix. The patient is no longer on any non-steroidal anti-inflammatory drugs, but is still documented as having upset stomach. The typical dosing for non-erosive and symptomatic gastroesophageal reflux disease is 20 mg daily. For erosive esophagitis or active ulcers, a higher dose may be appropriate but this is not documented. Therefore it is not evident why the injured worker requires a 10 mg pill in addition to the 20 mg pill. This request is not medically necessary.