

Case Number:	CM14-0022412		
Date Assigned:	05/07/2014	Date of Injury:	04/01/2013
Decision Date:	09/08/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/21/2014

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 Pain Medicine and Anesthesiology, and is licensed to practice in Connecticut. 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:

After careful review of the medical records provided, this is a 64-year-old female with complaints of neck and right upper extremity pain. The date of injury is 6/6/13 and the documented mechanism of injury is chronic "wear and tear" from her cleaning responsibilities involving lifting (30# max), mopping, sweeping, etc. At the time of request for the following: 1. tramadol HCL ER 150mg #60 2. Ondansetron 4mg #30 3. Pantoprazole 20mg #60 4. Ortho-nesic analgesic gel 6 Oz. tube 5. Naprosyn 500mg #60, there is documentation of subjective (neck and right shoulder/elbow pain) and objective (tender to palpation of right deltoid, positive neer and hawkins-kennedy tests, relatively preserved motor strength with restricted range of motion right arm), imaging findings (MRI of the cervical spine and right shoulder date 5/22/13 which shows supraspinatus tendinosis/acromioclavicular hypertrophy, multi-level disc protrusion C2/3 thru C6/7), diagnoses (right lateral epicondylitis, right shoulder pain/impingement syndrome, acromioclavicular osteoarthritis, cervicgia) and treatment to date (injections, medications). Tramadol has mu-agonist activity as well tri-cyclic characteristics and should be managed according to guidelines set for the prescribing of opioids. There are many documented cases of dependency and abstinence syndrome associated with Tramadol and establishment of a structured opioid prescribing program is strongly recommended. Ondansetron is a serotonin 5-HT3 receptor antagonist and is currently FDA approved for nausea and vomiting secondary to chemotherapy, anesthesia, and gastroenteritis. In regards to NSAIDS and PPI prophylaxis, there is no documentation of efficacy of pharmacologic treatment on her current analgesic drug regimen. The use of long-term Nsaids is not recommended unless there is documentation of benefits outweighing the risks.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL HCL ER 150MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR THE USE OF OPIOIDS Page(s): 76-78.

Decision rationale: Tramadol has mu-agonist activity as well tri-cyclic characteristics and should be managed according to guidelines set for the prescribing of opioids. There are many documented cases of dependency and abstinence syndrome associated with Tramadol. Per MTUS-Chronic Pain Medical Treatment Guidelines, establishment of a structured opioid prescribing program is strongly recommended. As there is no documentation of efficacy of treatment with tramadol, this medication should be discontinued. Therefore, the request is not medically necessary.

ONDANSETRON ODT 4MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (Zofran).

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

Decision rationale: This drug is a serotonin 5-HT₃ receptor antagonist. Per ODG, 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. There is no high-quality literature to support any one treatment for opioid-induced nausea in chronic non-malignant pain patients. Therefore, the request is not medically necessary.

PANTOPRAZOLE 20MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68.

Decision rationale: Per the MTUS Guidelines Chronic Pain Medical Treatment Guidelines, state that indications are for long term Nsaids use and higher doses may consider adjunctive PPI therapy. However, there is no documentation of efficacy of pharmacologic treatment on her current analgesic drug regimen. The use of long term Nsaids is not recommended unless there is

documentation of benefits outweighing the risks. Therefore, the request is not medically necessary.

ORTHO-NESIC ANALGESIC GEL 6 OZ TUBE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

Decision rationale: Per the MTUS Chronic Pain Medical Treatment Guidelines, there is little to no support in the literature for many compounded topical agents including menthol. The only FDA approved topical analgesics currently are voltaren gel, lidoderm, and capsaicin. Therefore, the request is not medically necessary.

NAPROSYN 00MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-68.

Decision rationale: Per the MTUS Chronic Pain Medical Treatment Guidelines, "There is inconsistent evidence for the use of these (NSAID) medications to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain." In addition, there is no documentation of efficacy of pharmacologic treatment on her current analgesic drug regimen. The use of long-term nsaid is not recommended unless there is documentation of benefits outweighing the risks. Therefore, the request is not medically necessary.