

Case Number:	CM14-0139322		
Date Assigned:	09/05/2014	Date of Injury:	06/04/2012
Decision Date:	06/05/2015	UR Denial Date:	08/01/2014
Priority:	Standard	Application Received:	08/28/2014

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. 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 60 year old female, who sustained an industrial injury on June 4, 2012. The injured worker was diagnosed as having cervicogenic headaches, C5-C6 and C6-C7 disc degeneration, left leg radiculopathy with weakness, L4-S1 disc degeneration, C5-C6 posterior disc protrusion, right greater trochanter bursitis, and left coronal plane deformity. Treatment to date has included electromyography (EMG)/nerve conduction study (NCS) of the bilateral upper and lower extremities, cervical spine/thoracic spine/lumbar spine/left shoulder MRIs, aqua therapy, and medication. Currently, the injured worker complains of continued ongoing daily and constant neck pain with radiation extending into the left upper extremity with associated headaches, and low back pain extending down the bilateral lower extremities with associated numbness in the feet. The injured worker rates her pain at 10/10 on the visual analog scale (VAS). The Primary Treating Physician's report dated July 15, 2014, noted the current medications as Norco, Xanax, Zofran, Voltaren gel, and Protonix. The injured worker was noted to walk with an antalgic gait, utilizing a seated walker for ambulation. Tenderness to palpation was noted in the cervical paravertebrals, across the trapezius bilaterally, with decreased sensory over the left C6 dermatome distribution. The injured worker was noted to have positive straight leg raise on the right at 80 degrees. The Physician requested authorization for a pain management consultation for cervical epidural steroid injection (ESI), a lumbar epidural steroid injection (ESI), and provided the injured worker with a prescription for Norco, and refills of Xanax, Zofran, and Protonix.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 month supply of Protonix: Upheld

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

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. (Donnellan, 2010) In this RCT omeprazole provided a statistically significantly greater acid control than lansoprazole. (Miner, 2010) 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. (AHRQ, 2011) A review of the injured workers medical records that are available to me did not show that she had tried and failed other first line recommended PPI's and therefore the request for 1 months supply of Protonix is not medically necessary.

Norco 5/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids Page(s): 74-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96 (78, 89, 95).

Decision rationale: Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, Opioids should be continued if the patient has returned to work or has improved functioning and pain. On-going management actions should include prescriptions from a single practitioner, taken as directed and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. Documentation should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long term users of opioids should be regularly reassessed. In the maintenance phase the dose should not be lowered if it is working. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected. When this happens opioids can actually increase rather than decrease sensitivity to noxious stimuli. It is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. A review of the injured workers medical records that are available to me do not reveal documentation of pain and functional improvement according to guideline recommendations for ongoing management with opioids, there is also no treatment regimen or quantity associated with the request and therefore medical necessity for the request for Norco 5/325mg is not medically necessary.

Xanax 0.05mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids Page(s): 74-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The MTUS does not recommend long term use of benzodiazepines, long term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to all of its effects develop within weeks to months, and long term use may actually increase anxiety, a more appropriate treatment for anxiety disorder is an antidepressant. Chronic benzodiazepines are the treatment of choice in very few conditions. A review of the injured workers medical records do not reveal extenuating circumstances that would warrant deviating from the guidelines, there is also no treatment regimen or quantity associated with the request and therefore medical necessity is not medically necessary.

Zofran 4mg: Upheld

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

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).

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 the request is for the treatment of opioid induced nausea, there is also no treatment regimen or quantity associated with the request and therefore medical necessity is not medically necessary.