

Case Number:	CM15-0011182		
Date Assigned:	01/29/2015	Date of Injury:	04/28/2010
Decision Date:	03/18/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/21/2015

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: District of Columbia, Virginia
Certification(s)/Specialty: Internal 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 41-year-old female, who sustained an industrial injury on 4/28/2010. The diagnoses have included bilateral knee internal derangement, bilateral knee degenerative menisci, bilateral knee patellofemoral pain, cervical discogenic disease, chronic cervical sprain/strain, right shoulder impingement with tendinitis, lumbar discogenic disease, lumbar facet disease, chronic low back pain, right carpal tunnel syndrome, and mild left shoulder impingement. Treatment to date has included medications, bracing of the neck and back, TENS unit, diagnostic imaging and modified activity. Magnetic resonance imaging (MRI) of the right shoulder dated 10/29/2014 revealed supraspinatus tendinosis and mild osteoarthropathy of acromioclavicular joint. Currently, the IW complains of worsening pain in the right shoulder, rated as a 9/10. She reported difficulty sleeping due to the pain. She also reported chronic cervical pain, bilateral upper extremity right greater than left radicular pain, chronic bilateral knee pain, and low back pain. Objective findings included a positive Tinel's and Phalen's sign in the right hand. McMurry's test is positive bilaterally. There is patellofemoral crepitus and joint line pain in the bilateral knees. On 12/23/2014, Utilization Review modified a request for Motrin 100mg #60, Prilosec 20mg #60, Ultram 200mg #30 and non-certified a request for Klonopin 1mg #60 noting that the clinical findings do not support the medical necessity of the treatment. The MTUS was cited. On 1/21/2015, the injured worker submitted an application for IMR for review of Motrin 800mg #60, Prilosec 20mg #60, Ultram 200mg #30 and Klonopin 1mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines: Omeprazole

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation proton pump inhibitors

Decision rationale: MTUS does not address this medication. Per ODG: proton pump inhibitors (PPI) are recommended for patients at risk for gastrointestinal events. See NSAIDS, GI symptoms and cardiovascular risk. Prilosec (omeprazole), Prevacid (lansoprazole), and nexium (esomeprazole) are PPIs. Omeprazole provides a statistically significantly greater acid control than lansoprazole (Miner 2010). Healing doses of PPIs are more effective than all other therapies although there is an increase in overall adverse effects to placebo. Nexium and Prilosec are very similar molecules. For many people, Prilosec is more affordable than nexium. Nexium is not available in a generic (as in Prilosec). Also, Prilosec is more available as an over the counter product while nexium is not. (Donnellan 2010) In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose or the shortest possible amount of time. PPIs are more effective 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. If a PPI is used, omeprazole OTC tablets or lansoprazole 24 HR OTC are recommended for an equivalent clinical efficacy and significant cost savings. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including nexium, prevacid, Prilosec, Protonix, Dexilant, and aciphex (Shi 2008). A trial of omeprazole or lansoprazole is recommended before nexium therapy. The other PPIs, Protonix, Dexilant, aciphex should also be second line. According to the latest AHRQ comparative effectiveness research, all of the commercially available PPIs appeared to be similarly effective (AHRQ 2011) (Pain Chapter). This patient did not have risk factors which would warrant chronic usage of Prilosec. This medication would not be indicated.

Ultram ER 200mg #30 with 4 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 93-94,113.

Decision rationale: Per MTUS: Tramadol (Ultram; Ultram ER; generic available in immediate release tablet): Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is not classified as a controlled substance by the DEA. Side Effects: Dizziness, nausea, constipation, headache, somnolence, flushing, pruritus, vomiting, insomnia, dry mouth, and diarrhea. Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs

and other opioids. Do not prescribe to patients that at risk for suicide or addiction. Warning: Tramadol may produce life-threatening serotonin syndrome, in particular when used concomitantly with SSRIs, SNRIs, TCAs, and MAOIs, and triptans or other drugs that may impair serotonin metabolism. Analgesic dose: Tramadol is indicated for moderate to severe pain. The immediate release formulation is recommended at a dose of 50 to 100mg PO every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 to 6 hours (max 400mg/day). Ultram ER: Patient currently not on immediate release tramadol should be started at a dose of 100mg once daily. The dose should be titrated upwards by 100mg increments if needed (Max dose 300mg/day). Patients currently on immediate release tramadol, calculate the 24-hour dose of IR and initiate a total daily dose of ER rounded to the next lowest 100mg increment (Max dose 300mg/day). (Product information, Ortho-McNeil 2003) (Lexi-Comp, 2008) Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. For more information and references, see Opioids. See also Opioids for neuropathic pain. This patient had chronic pain issues which were treated concurrently with Motrin and tramadol. As per guidelines, tramadol is not a first line medication and would not be indicated for this patient.

Klonopin 1mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 24.

Decision rationale: Per MTUS: Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005) Chronic usage of this medication would not be indicated due to habit-forming properties.