

Case Number:	CM15-0063070		
Date Assigned:	04/08/2015	Date of Injury:	02/09/1994
Decision Date:	05/14/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/02/2015

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: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 66 year old female, who sustained an industrial injury on February 9, 1994. She has reported right wrist pain. Diagnoses have included right carpal tunnel syndrome, and chronic gastroesophageal reflux disease. Treatment to date has included medications and carpal tunnel release. A progress note dated February 19, 2015 indicates a chief complaint of chronic right wrist pain. The treating physician documented a plan of care that included medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

NEXIUM 40MG # 30 REFILLS 11: 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 NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68. Decision based on Non-MTUS Citation ODG, Pain, Proton Pump Inhibitors.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (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). CPMTG guidelines further specify: "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 cardio-protection) 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)" Per ODG TWC, "many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. A trial of omeprazole or lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line." The documentation submitted for review indicates that the injured worker suffers from chronic GERD secondary to medication use. However, as noted per the guidelines, Nexium is a second-line medication. The medical records do not establish whether the patient has failed attempts at first line PPIs, such as omeprazole or lansoprazole, which should be considered prior to prescribing a second line PPI such as Nexium. The request is not medically necessary.

ULTRAM 50MG # 90 WITH 11 REFILLS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 93.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding on-going management of opioids; "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. These domains have been summarized as the "4 A's" (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the available medical records reveals no documentation to support the medical necessity of Ultram nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going

management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Furthermore, efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing this concern in the records available for my review. As MTUS recommends to discontinue opioids if there is no overall improvement in function, medical necessity cannot be affirmed. Furthermore, a one year supply would not allow for timely reassessment of efficacy. The request IS NOT medically necessary.