

Case Number:	CM13-0046591		
Date Assigned:	12/27/2013	Date of Injury:	12/15/2006
Decision Date:	04/03/2014	UR Denial Date:	10/15/2013
Priority:	Standard	Application Received:	11/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 physician 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:

This is a female patient with the date of injury of December 15, 2006. A Pain Medicine Re-evaluation report dated October 2, 2013 identifies Subjective Complaints of upper extremity pain on the right arm and lower extremity pain in the right knee. Physical examination identifies cervical lordosis is decreased. There is spasm noted in the right trapezius muscle and in the right paraspinal muscles. Spinal vertebral tenderness was noted in the cervical spine C4-7. There was tenderness noted in the right trapezius muscle, right paravertebral area upon palpation and right occipital area upon palpation. The range of motion of the cervical spine was moderately limited due to pain. Tenderness is noted at the right anterior shoulder and right posterior shoulder. The range of motion of the right shoulder was decreased due to pain, right elbow decreased due to pain, and right wrist decreased due to pain. Decreased strength of the extensor muscles and flexor muscles in the right lower extremity. Diagnoses identify cervical strain/sprain, chronic pain other, comminuted fracture of right radius, status post joint replacement surgery at right elbow. Treatment Plan identifies renew current medications as presently prescribed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pantoprazole 20mg Qd #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms, and Cardiovascular Risk.

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 Chapter, Proton Pump Inhibitors (PPIs)

Decision rationale: California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Additionally, ODG recommends Nexium, Protonix, Dexilant, and AcipHex for use as 2nd line agents, after failure of omeprazole or lansoprazole. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. Furthermore, there is no indication that the patient has failed first-line agents prior to initiating treatment with Pantoprazole (a 2nd line proton pump inhibitor). In the absence of clarity regarding those issues, the currently requested Pantoprazole 20mg Qd #30 is not medically necessary.

Tizanidine 4mg one q12hrs # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

Decision rationale: Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Zanaflex. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Tizanidine 4mg one q12hrs # 60 is not medically necessary.