

Case Number:	CM13-0050208		
Date Assigned:	06/09/2014	Date of Injury:	04/28/2008
Decision Date:	08/04/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/11/2013

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 Anesthesiology, has a subspecialty in Acupuncture & Pain Medicine 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 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:

Claimant is a 49 year old male injured worker with date of injury 4/23/08 with related left shoulder, neck and low back pain. Per 10/31/13 note, he had left shoulder pain rated 3-4/10 in intensity. He reported radiation of pain from his shoulder into his biceps region. He denied numbness or tingling. He has had left shoulder surgery, which had included open Mumford procedure and decompression. Electromyography dated 7/19/10 revealed evidence of moderate bilateral median mononeuropathy at the wrist. MRI of the left shoulder dated 9/9/10 showed a Superior Labrum Anterior Posterior lesion. He has been treated with surgery, physical therapy, and medication management. The date of UR decision was 10/22/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

PANTOPROZOLE-PROTONIX 20MG OD #60: Overturned

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 Official Disability Guidelines (ODG) Pain, Proton Pump Inhibitors.

Decision rationale: In the treatment of dyspepsia secondary to Non-steroidal anti-inflammatory drug (NSAID) therapy, the California Medical Treatment Utilization Schedule (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 cardioprotection) 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 Official Disability Guidelines (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." It is noted in the documentation that the injured worker has a history of heart burn and GI side effects secondary to Celebrex and vicodin use. Per 10/31/13 note, he is using ibuprofen which can cause GI upset, nausea and heartburn. It is noted that he had used Prilosec in the past without much benefit. I respectfully disagree with the UR physician's assertion that the injured worker was not at risk for gastrointestinal complications. The request is medically necessary.

TIZANIDINE-ZANAFLEX 4MG 1/2 TAB PRN #90 DISPENSED 04/19/2013 FOR LEFT SHOULDER: Overturned

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 Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: Per California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines p66 "Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain." Per 11/5/13 visit note, it was noted that the injured worker experiences muscle spasms intermittently in his neck and left shoulder. "He does not take the Zanaflex during

the day but does take it nightly as he feels it is incredibly helpful for sleep. He notes it relaxes him enough to allow him to sleep." I respectfully disagree with the UR physician. Per documentation which was not available to him, there is evidence of acute myospasm supporting the use of this medication. The request is medically necessary.