

Case Number:	CM13-0052686		
Date Assigned:	12/30/2013	Date of Injury:	08/20/2003
Decision Date:	05/29/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	11/01/2013

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 Physical Medicine & Rehabilitation 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:

The patient has submitted a claim for lumbar sprain, lumbar disc degeneration, and lumbar disc displacement associated with an industrial injury date of 08/20/2003. Treatment to date has included lumbar fusion surgery on unspecified date, physical therapy, and medications such as tizanidine, pantoprazole, diclofenac sodium, and hydrocodone/acetaminophen. Medical records from 2013 to 2014 were reviewed showing that patient complained of low back pain with intermittent left lower extremity pain aggravated upon bending or twisting. The patient likewise complained of right shoulder pain worse with overhead activities. Physical examination showed tenderness at right acromioclavicular joint, and lateral deltoid. Motor strength of bilateral lower extremities was graded 5/5. Neurologic exam was intact. Gait was normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

PROTONIX, PANTOPROZOLE SODIUM, DR 20MG #60 WITH 3 REFILLS:

Overtured

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: As stated on page 68 of Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients at intermediate risk for gastrointestinal events should be given a non-selective NSAID with either a proton pump inhibitor or misoprostol. In this case, the prescribed medications for the patient include diclofenac sodium 100mg and aspirin, two NSAIDs, as cited in an appeal letter dated 01/09/2014. This validates the patient as having an intermediate risk for gastrointestinal events. The medical necessity for a proton pump inhibitor has been established per the recommendations as stated above. Therefore, the request for Protonix DR 20mg with 3 refills is medically necessary.

NORCO, HYDROCODONE/APAP, 5/325MG # 60 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

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

Decision rationale: As stated on page 78 of MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related 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. In this case, the patient has been prescribed hydrocodone since 2012. An appeal letter dated 01/09/2014 stated that patient has been prescribed with both tramadol and diclofenac; and the purpose of Norco is to control his breakthrough pain. The most recent urine drug screen dated 12/20/2013 confirmed levels of hydrocodone and hydromorphone. However, medical records submitted and reviewed do not specifically show that there is significant pain improvement with the use of this medication (i.e. documented pain reduction in terms of VAS / pain scale), as well as monitoring of any side effects attributed to its use. The guideline criteria have not been met. Therefore, the request for Norco 5/325mg with 3 refills is not medically necessary.

ZANAFLEX, TIZANIDINE, 4MG #60 WITH 3 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

Decision rationale: According to page 63 of Chronic Pain Medical Treatment Guidelines, recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case,

the initial date of intake of this medication is not documented in the medical records submitted. An appeal letter dated 01/09/2014 stated that tizanidine was prescribed to control his chronic muscle spasm. However, tizanidine is not recommended for long-term treatment as recommended by the guidelines stated above. Furthermore, the physical examination based on the most recent progress reports did not provide evidence of muscle spasm. Therefore, the request for Zanaflex 4mg with 3 refills is not medically necessary.