

Case Number:	CM14-0011721		
Date Assigned:	02/21/2014	Date of Injury:	07/18/2011
Decision Date:	06/25/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/29/2014

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 Texas. 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 injured worker is a 50-year-old male who reported an injury on 07/18/2011 due to a motor vehicle accident that reportedly caused injury to the right femur, rib fractures, a punctured lung, and zygoma fracture, and a thoracic spine fracture. The injured worker's treatment history included multiple surgical interventions, extensive physical therapy, and multiple medications. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 12/09/2013. It was documented that the injured worker had ongoing neck, thoracic, lumbar, and right shoulder pain. Physical findings included a limited range of motion of the upper and lower extremities, and low back secondary to pain. The injured worker's medications included cyclo-gaba cream, diclofenac sodium 100 mg, hydrocodone 2.5/325 mg, and pantoprazole 20 mg. The injured worker's diagnoses included neck pain, thoracic pain, low back pain, leg pain, status post thoracic vertebral fracture, lumbar mechanical pain, chronic pain, closed head injury, lumbar discogenic pain, lumbar sprain/strain, and scoliosis. The injured worker's treatment plan included continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

REFILL PANTOPRAZOLE (PROTONIX) TABLET 20 MG, 1 PER MORNING, QTY: 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL

TREATMENT GUIDELINES, CHAPTER: NSAIDS (NON-STEROIDAL ANTI-INFLAMMATORY DRUGS),

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: The requested pantoprazole (Protonix) tablets 20 mg, 1 per morning, quantity 30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the use of gastrointestinal protectants for injured workers at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation does indicate that the injured worker has been on this medication for an extended duration. However, the injured worker's most recent clinical documentation does not provide and adequate assessment of the injured worker's gastrointestinal system to support that they are at continued risk for developing gastrointestinal symptoms related to medication usage. Therefore, ongoing use of this medication would not be supported. As such, the requested refill of pantoprazole (Protonix) tablets 20 mg, 1 per morning, quantity 30 is not medically necessary or appropriate.