

<b>Case Number:</b>	CM14-0131337		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	05/16/1989
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	07/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2014

### 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 Family Practice, and is licensed to practice in Texas and Mississippi. 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 60 year old male who reported an injury on 05/16/1989 due to an unknown mechanism. Diagnoses were mature C6-7 interbody fusion, cervical spondylosis, and central C4-5 disc protrusion impinging on the ventral cord. Past treatments have been epidural steroid injections and acupuncture. Diagnostic studies were MRI of the cervical spine without contrast. Surgical history was cervical fusion. Physical examination on 08/07/2014 revealed complaints of chronic pain and back pain. The injured worker reported he had increased low back pain that radiated into the right leg. The injured worker had undergone a lumbar epidural steroid injection, but there was no indication that it offered any significant relief. Examination revealed lumbar spine tenderness to palpation at the lumbosacral junction. Range of motion of the lumbar spine was decreased by 60% with flexion, 30% with extension. Sensations were decreased to light touch along the left lateral thigh compared to the right lower extremity. Medications were Protonix, Norco, and Tizanidine. The treatment plan was to continue medications as directed. The rationale was submitted. The Request for Authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Prescription of Pantoprazole-Protonix 20mg #30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic) Proton pump inhibitors (PPIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**Decision rationale:** The decision for 1 Prescription of Pantoprazole-Protonix 20mg #30 is not medically necessary. Clinicians should determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. 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. For patients at high risk for gastrointestinal events with no cardiovascular disease, a Cox-2 selective agent is recommended plus a PPI if absolutely necessary. The request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

**1 Prescription of Tizanidine-Zanaflex 4mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (May 2009) regarding Tizanidine (Zanaflex); Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine Page(s): 66.

**Decision rationale:** The decision for 1 Prescription of Tizanidine-Zanaflex 4mg #90 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend Tizanidine (Zanaflex) as a non-sedating muscle relaxant with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. It was not reported that the injured worker was having an acute exacerbation of low back pain. This medication is not meant to be on for a long term treatment. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.