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| Case Number: | CM14-0137750 | | |
| Date Assigned: | 09/05/2014 | Date of Injury: | 12/03/2010 |
| Decision Date: | 10/27/2014 | UR Denial Date: | 08/07/2014 |
| Priority: | Standard | Application Received: | 08/26/2014 |

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 and Rehabilitation, has a subspecialty in 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:

The injured worker is presented with a date of injury of 12/3/10. A utilization review determination dated 8/7/14 recommends non-certification of Protonix, Flexeril, and Voltaren ER. It referenced a 7/11/14 medical report identifying pain in the right shoulder, ankle foot, and bilateral knees. On exam, there was limited shoulder ROM with positive Neer's and Hawkins', right knee tenderness and effusion with pain with McMurray test, crepitus, left knee crepitus and effusion, tenderness about the medial joint line, pain with McMurray test, right ankle tenderness.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Protonix 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68-69 OF 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors (PPIs)

Decision rationale: Regarding the request for Protonix, 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, the Official Disability Guidelines (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 retrospective request for Protonix 20 mg #60 is not medically necessary and appropriate.

Retro Flexeril 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 OF 127.

Decision rationale: Regarding the request for Flexeril, the 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. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. 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 retrospective request for Flexeril 7.5mg #90 is not medically necessary and appropriate.

Retro Voltaren ER 100mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68,71.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 67-72 OF 127.

Decision rationale: Regarding the request for Voltaren ER, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that the medication is providing any specific analgesic benefits (in terms of percent pain reduction or reduction in numeric rating scale) or any objective functional improvement. In the absence of such documentation, the retrospective request for Voltaren ER 100 mg #30 is not medically necessary and appropriate.