

Case Number:	CM14-0038276		
Date Assigned:	06/25/2014	Date of Injury:	11/26/2011
Decision Date:	09/17/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	04/01/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in New Jersey. 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 is a 28-year-old man who sustained a work-related injury on November 26, 2011. He subsequently developed severe lower back pain. The patient underwent L2-3 discectomy performed on April 24, 2013 without any significant improvements in his pain. According to a progress report dated January 7, 2014 stated that the patient was disabled by a severe back pain radiating to bilateral lower extremities. The patient underwent lumbar epidural steroid injection without benefit. He reported that tramadol ER did not adequately work to relieve his pain. He has been trialed on other pain medications including Nabumetone, Flexeril, and Gabapentin for which he reported no benefit. Physical examination revealed symmetric and full strength in the bilateral lower extremities with preservation of deep tendon reflexes. Gait is slow and antalgic with weight bearing favored on the left leg. The patient was diagnosed with multilevel disc degeneration with multilevel protrusions and associated neural foraminal stenosis and central canal stenosis, chronic pain syndrome, depression, and insomnia. The provider requested authorization to use Cyclobenzaprine, and Pantoprazole.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: According to MTUS guidelines, Cyclobenzaprine, a nonsedating muscle relaxant, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The guidelines do not recommend to be used for more than 2-3 weeks. The patient in this case does not have clear significant functional improvement with prior use of muscle relaxants. There is no indication of recent evidence of spasm. Therefore, the request for Cyclobenzaprine tablets 7.5mg #90 is not medically necessary.

Pantoprazole 20mg #60:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: According to MTUS guidelines, Pantoprazole as well as other proton pump inhibitors are recommended when NSAIDs are used in patients with intermediate or high risk for gastrointestinal events. The risk for gastrointestinal events are: (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). There is no documentation in the patient's chart supporting that he is at intermediate or high risk for developing gastrointestinal events. Furthermore, there is no documentation that the patient is currently taking NSAIDs. Therefore, Pantoprazole 20 mg # 60 mg is not medically necessary.