MAXIMUS Federal Services

Case Number:	CM14-0042363		
Date Assigned:	06/30/2014	Date of Injury:	03/15/2012
Decision Date:	09/22/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	04/08/2014

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 37 year old employee with date of injury of 3/15/2012. Medical records indicate the patient is undergoing treatment for hypertension, gastroesopahgeal reflux disease and sleep apnea, HTN with LT Vent DD, retinal branch vein occlusion on left eye and diastasis, cervical/lumbar discopathy and right shoulder impingement with MRI evidence of slap lesion tear, full thickness supraspinatus tear, subscapularis partial tear and partial infraspinatus tendon tear. She also has s/p left wrist surgery by history, s/p lumbar fusion in 2009, bilateral cubital tunnel syndrome, carpal tunnel/double crush syndrome, s/p bilateral medial knee replacement and internal derangement bilateral knees. Subjective complaints include persistent pain of the neck that is aggravated by repetitive motions of the neck. Persistent or prolonged positioning of the neck, pushing, pulling, lifting, forward reaching and working above the shoulder level cause pain. The patient also has low back pain that is aggravated by bending, lifting, twisting, pushing, pulling, sitting, standing and walking multiple blocks. Objective findings include tenderness of the cervical paravertebral muscles and upper trapezial muscles with spasm. Axial loading compression test and Spurling maneuver are both positive. There is painful restricted cervical range of motion (ROM). There is dysesthesia at the C6 and C7 dermatomes. Upon exam of the right shoulder there is tenderness anteriorly. There is a positive impingement sign and pain with terminal motion. Exam of the bilateral elbows reveals a positive Tinel's sign, there is tenderness at the olecranon fossa and there is pain with terminal flexion. There is dysesthesia at the ulnar two digits. There is tenderness at the volar aspect of the bilateral wrists. There is tenderness at the A1 pulley of the bilateral thumb, right greater than left with triggering. The patient has a weak grip and dysesthesia at the radial digits. There is tenderness at the lumbar paravertebral muscles and pain with terminal motion. Seated nerve root test is positive. There is dysesthesia at the L5 and S1 dermatomes. There is tenderness at the knee joint anteriorly and pain with

terminal flexion. Patient has tenderness in the heel cord extending into the plantar fascia into the sole; consistent with possible plantar fasciitis. Treatment has consisted of Cosamine DS, Norco, Protonix and Motrin. The utilization review determination was rendered on 3/13/2014 recommending non-certification of Protonix 20 mg #90 (date of service 01/24/2013); Protonix 20 mg #90 (date of service 12/10/2012) and Hemodynamic Study (date of service 12/10/2012).

IMR ISSUES, DECISIONS AND RATIONALES

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

Protonix 20 mg #90(date of service 01/24/2013): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines, PPI's Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: MTUS states, "Determine if the patient is at risk for gastrointestinal events: (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)." And, "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 (adjusted odds ratio 1.44)." ODG states, "If a PPI is used, omeprazole OTC tablets or lansoprazole 24HR OTC are recommended for an equivalent clinical efficacy and significant cost savings. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec), pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). (Shi, 2008) A trial of omeprazole or lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line. According to the latest AHRQ Comparative Effectiveness Research, all of the commercially available PPIs appeared to be similarly effective. (AHRQ, 2011)." The medical documents provided establish the patient has reflux disease and the patient had a failed trial of Prevacid. However, the treating physician has not provided detailed documentation of a failed trial of omeprazole prior to starting Protonix therapy. As such, the request for Protonix 20 mg #90 (date of service 01/24/2013) is not medically necessary.

Protonix 20 mg #90 (date of service 12/10/2012): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's. Decision based on Non-MTUS Citation Official Disability Guidelines, PPI's Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: MTUS states, "Determine if the patient is at risk for gastrointestinal events: (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)." And "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 (adjusted odds ratio 1.44)." ODG states, "If a PPI is used, omeprazole OTC tablets or lansoprazole 24HR OTC are recommended for an equivalent clinical efficacy and significant cost savings. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec), pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). (Shi, 2008) A trial of omeprazole or lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line. According to the latest AHRQ Comparative Effectiveness Research, all of the commercially available PPIs appeared to be similarly effective. (AHRQ, 2011)." The medical documents provided establish the patient has reflux disease and the patient had a failed trial of Prevacid. However, the treating physician has not provided detailed documentation of a failed trial of omeprazole prior to starting Protonix therapy. As such, the request Protonix 20 mg #90 (date of service 12/10/2012) is not medically necessary.

Hemodynamic Study (date of service 12/10/2012): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation hhtp://www.bebsms.com/com/bebsms/apps/PolicySearch/views/ViewPolicy.php?&noprint=yes &path-%2Fpolicy%2Femed%2Plethysmography.html (last updated 10/01/2008).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:http://www.uptodate.comUpToDate, Noninvasive diagnosis of arterial disease.

Decision rationale: Plethysmography is a noninvasive technique for measuring blood flow to an organ, body region or limb. Uptodate states, "The main purpose of physiologic testing is to verify a vascular origin for a patient's specific complaint. Other goals, depending upon the clinical scenario, are to localize the level of obstructive lesions and assess the adequacy of tissue perfusion and wound healing potential".Uptodate states that Noninvasive vascular testing may be performed to: Screen patients who have risk factors for PAD. Patients with asymptomatic lower extremity PAD have an increased risk of myocardial infarction, stroke, and cardiovascular mortality and benefit from identification to provide risk factor modification [3-8]. Similarly,

asymptomatic patients with risk factors for aneurysm or cerebrovascular disease may be screened to identify these conditions and stratify management. Confirm a diagnosis of arterial disease in patients with symptoms or signs consistent with an arterial pathology. Identify a vascular injuryEvaluate patients prior to or during planned vascular procedures.Provide surveillance after vascular intervention.The treating physician has not provided evidence of previous vascular intervention, calf pain, claudication, vascular injury, and/or documentation of a concern for tissue perfusion and wound healing. The treating physician has not provided a clear rationale as to why a hemodynamic study is needed at this time and has not met the above guidelines. As such, the request for Hemodynamic Study (date of service 12/10/2012) is not medically necessary.