MAXIMUS Federal Services

Case Number:	CM14-0055407		
Date Assigned:	07/07/2014	Date of Injury:	10/28/2004
Decision Date:	08/29/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	04/24/2014

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 53 year old employee with date of injury of 10/28/2004. Medical records indicate the patient is undergoing treatment for dysphagia, severe spastic esophageal dysmotility, and dental deterioration secondary to opiate therapy, traumatic DJD to knees secondary to falls, EPS from TBI, history of head and spine injury with neurological deficits (2004) and chronic pain treated with opioids. The patient is status-post thoracolumbar spinal fusion from T10-S1 with pelvic fixation on 3/13/2013. He is also post-status 2 lumbar laminectomies in 2007 and 2008. He is also status-post cervical spine fusion of C5-7 in 2006. He has L4 radiculopathy with acute and chronic pain and weakness as well as intermittent paraparesis from numbers 4 to 7 and diffuse muscle spasm of the spine. He has cervical radiculopathy and myelopathy with secondary cerviogenic and migraine headaches. It is noted that the patient also suffers from depression, paranoia and delusions. Subjective complaints include back and neck pain. The patient also complains of persistent dysphagia, worse with solid food which does occur occasionally with water and other liquids. He complains of suffering from a few episodes of food impaction lasting for a few minutes before regurgitation with severe pain. The physician noted that the patient has a very complex esophageal motility disorder that is spastic in nature and possibly a variant of achalasia. He also complains of ongoing low back pain that radiates to the anterior thighs which causes his legs to go numb. When this occurs, he cannot keep his legs straight to stand. His knee pain and swelling are such that it makes it difficult to transfer and walk. Objective findings include a progress report dated 3/3/2014 indicates that the patient has dysphagia. On exam, his extraocular movements were saccadic. His Masseter strength was intact. When he swallowed, his saliva would "catch" causing him to clear his throat. His jaw reflex was not present. His palate and tongue were midline and a gag reflex was present. His sternocleidomastoid and trapezius muscles were strong. He has no clubbing, cyanosis or edema to his extremities; however, there

were effusions of both knees with crepitus and instability on the left. His muscle tone was increased but there was decrease in bulk on the right calf. Strength testing slowed RAMs on the right. His legs could not be tested due to knee pain. Muscle spasms were present across the entire spine and there were crossed adductors. There was no Hoffman's present. His toes did not respond. Heel to shin testing could not be completed and he could not do a tandem walk. He did have endpoint tremors. He could not walk on heels and toes. Gait and station were wide-based, shuffling and antalgic. He had to use both arms maximally to rise from a sitting position. He had sensation to light touch. Pinprick was decreased in right anterior thigh. His double simultaneous simulation was intact. There was no pronator drift. The Romberg's sign was positive. Treatment has consisted of an (unsuccessful) trial of Diltiazem. The physician requested to perform an EGD and Botox trial. He has been on (high doses) of both Methadone and Hydrocodone. Other medications that the patient has been prescribed include: Norco, Valium, Gabapentin, Opana, Pristiq, Protonix, Restoril, Requip, Seroquel, Treximet PO, Tricor and Wellbutrin SR. He has been an ordered a dental consult and was pending T&TD surgery on his low back. He requires 24/7 care from an attendant. The utilization review determination was rendered on 4/15/2014 recommending non-certification of a prospective request for one (1) prescription of Protonix 40 mg #60 with 11 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for one (1) prescription of Protonix 40 mg #60 with 11 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): page 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)." While Protonix may be appropriate for the treatment of dyspepsia secondary to NSAIDS, the treating physician notes on 3/3/14 that NSAIDS were discontinued due to GI risk with long term use. In addition, the medical documents provided do not establish the patient as having documented GI bleeding/perforation/peptic ulcer or other GI risk factors as outlined in MTUS. As such, the request for Prospective request for one (1) prescription of Protonix 40 mg #60 with 11 refills is not medically necessary.