

Case Number:	CM14-0138271		
Date Assigned:	09/05/2014	Date of Injury:	01/17/2007
Decision Date:	09/30/2014	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 Family Medicine and is licensed to practice in North Carolina. 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 51-year-old with a reported date of injury of 01/17/2007 that occurred after a slip and fall that resulted in a fractured fibula. The patient has the diagnoses of pain in joint/ankle and degenerative lumbar/lumbosacral disc disease. Past treatment modalities have included surgical intervention of the ankle and physical therapy. Per the progress notes by the primary treating and requesting physician dated 07/10/2014, the patient had complaints of chronic left ankle and low back pain. The physical exam noted an antalgic gait, tenderness to palpation at the lumbosacral junction on the left side, decreased lumbar range of motion, and decreased sensation to light touch along the left lower extremity compared to the right lower extremity. Treatment recommendations included continuation of medications and a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pantoprazole Tab 20mg, #30 (for a 30 day supply): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors (NSAIDS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ODG proton pump inhibitors; Protoni product insert.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested medication. The California MTUS addresses the use of proton pump with NSAIDs but this patient is not on a NSAID. PER the ODG: Recommended for patients at risk for gastrointestinal events. Prilosec provides a statistically significant greater acid control than Prevacid. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. If a Proton Pump Inhibitors (PPI's) is used, Omeprazole over the counter (OTC) or Lansoprazole OTC are recommended for an equivalent clinical efficacy. A trial of Prilosec or Prevacid is recommended before Nexium. Protonix, Dexilant and Aciphex should be considered second-line agents. Per the product insert for the requested medication, Protonix is indicated for the short term treatment for the healing and relief of symptoms of acid -related damage to the esophagus known as erosive esophagitis or erosive gastrointestinal reflux disease. The California MTUS defines gastrointestinal events as Gastrointestinal (GI) bleeds, peptic ulcer disease and perforation. Per the utilization appeal letter from the requesting physician, the patient has a history of GI complications such as frequent heartburn and excessive gas secondary to the use of oral medications. There is no documentation of the patient failing the recommended first line agent. There patient does not have the established indications of erosive esophagitis or erosive GERD. The patient does not have a history of the defined gastrointestinal events. For these reasons criteria have not been met and the request is not medically necessary and appropriate.

Zolpidem ER tab 6.25mg, #30 (for a 30 day supply): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Sleep Aids, Zolpidem.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested medication. The ODG states that zolpidem is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7-10 days. Zolpidem ER is indicated for insomnia with difficulty of sleep onset or sleep maintenance for up to 24 weeks in adults. The patient does have documentation of a sleep disorder most specifically with sleep maintenance and sleep onset. The requested medication is a recommended agent per the ODG for these diagnoses and thus is medically necessary and appropriate.