

<b>Case Number:</b>	CM13-0034003		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	11/08/2001
<b>Decision Date:</b>	04/26/2014	<b>UR Denial Date:</b>	09/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/11/2013

### 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 and is licensed to practice in Texas. 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 53-year-old male who reported an injury on 11/08/2001. The mechanism of injury was not stated. The patient is currently diagnosed with post-laminectomy syndrome, displacement of lumbar intervertebral disc without myelopathy, and other pain disorder related to psychological factors. The patient was seen by [REDACTED] on 11/27/2013. The patient reported persistent lower back pain with right lower extremity numbness as well as depression and anxiety. Physical examination on that date revealed an antalgic gait, 2+ deep tendon reflexes with the exception of absent Achilles bilaterally, diminished sensation to light touch at the right S1 dermatomal distribution, 2+ muscle spasm noted over the lumbar paraspinal, and a forward flexed body posture. The treatment recommendations at that time included continuation of current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PREVACID 30MG, #30, WITH FIVE (5) REFILLS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs  
Page(s): s 68-69.

**Decision rationale:** California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. As per the documentation submitted, the patient has utilized Prevacid 30 mg since at least 06/2013. However, there is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria as outlined by California MTUS Guidelines. As such, the request is non-certified.

**NORCO 10-325MG, #120, WITH FIVE (5) 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 Opioids Page(s): s 74-82. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , PAGE 74-82

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has utilized Norco 10/325 mg every 4 to 6 hours on an as needed basis since at least 06/2013. Despite ongoing use of this medication, the patient continues to report persistent pain. The patient also reports numbness in the right lower extremity and interference with sleep. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.