

<b>Case Number:</b>	CM13-0034332		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	05/09/2013
<b>Decision Date:</b>	03/24/2014	<b>UR Denial Date:</b>	09/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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 physician 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 64 year old male who was injured on 05/09/2013 while at work when the cart started rolling quickly and struck him from behind sustaining lower back injury. Prior treatment history included pain medications and physical therapy. EMG/NCS of lower extremities dated 10/07/2013 showed the smaller than expected left peroneal CMAP amplitude is indicative of left chronic L5 radiculopathy. Electromyographic indicators of acute lumbar radiculopathy were not seen. No electroneurographic evidence of entrapment neuropathy was seen in the lower extremities. A progress note 11/13/2013 showed the patient has been having some flare-ups in lower back pain with the colder weather and attempts to increase activity. There was tenderness to palpation in the left upper, mid and lower paravertebral muscles of the lumbar spine. There was increased pain with lumbar motion. There was a list with lumbar. There was patchy, decreased sensation in the left lower extremity, mostly notably in the L5 and S1 distribution. He was diagnosed with left lumbar radiculopathy and degenerative joint/degenerative disc disease of the lumbar spine with disc protrusions at L1-L2, L2-L3, L3-L4, L4-L5 and L5-S1 was found. Recommendation was Anaprox 550mg #60 and Protonix 20mg#30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 month supply of Anaprox:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), Page(s): 67-68.

**Decision rationale:** This patient was diagnosed with left lumbar radiculopathy and degenerative joint/disc disease. CA MTUS pain medical treatment guidelines recommend NSAIDs as a second-line treatment after acetaminophen for acute exacerbations of chronic low back pain. The submitted records do not document that he was prescribed acetaminophen first and hence the request is non-certified.

**1 month supply of Protonix:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSIADs, GI symptoms and cardiovascular risk, Page(s): 68-69.

**Decision rationale:** As per CA MTUS guidelines, PPI is recommended for patients at intermediate risk for gastrointestinal events and no cardiovascular disease. Long-term PPI use has been shown to increase the risk of hip fracture. There is no documentation that this patient reported any GI upsets, and hence the medical necessity is not established. Thus, the request is non-certified.

**1 month supply of Tylenol #3:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use, Criteria for use of opioids Page(s): 76-82.

**Decision rationale:** The request for Tylenol #3 is non-certified. There is no documentation provided for my review that indicates this patient was prescribed this medication. The frequency of intake was not provided for my review. There is insufficient information available for my review to determine the medical necessity and hence the request is non-certified.