

Case Number:	CM13-0036263		
Date Assigned:	12/13/2013	Date of Injury:	07/30/2003
Decision Date:	03/31/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/18/2013

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 Internal 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:

The patient is a 46-year-old male who was injured on July 30, 2003. The patient fell approximately 12 feet, sustaining a right temporal contusion as well as a C6 C7 fractures dislocation. He was complaining of neck pain and numbness below the waist. He was not able to move his legs. Prior treatment history has included spinal cord/brain injury rehabilitation physical therapy, epidural steroid injections (ESI), ophthalmology treatments, occupational therapy, transcutaneous electrical nerve stimulation (TENS) unit therapy, psychological assessment, lower extremity brace, Botox injection, cervical block, and home neck and low back exercise program. In 2003, the patient underwent stabilization with a C5-T2 cervical-thoracic fusion and given a Halo brace. Records reviewed included the Medical Record Review from ANS Solutions dated December 03, 2013, which itemized treatments and consultations all the way back to 2003. The patient was diagnosed with spinal cord injury, incomplete C6 quadriplegia, traumatic brain injury, neurogenic bowel and bladder, low back pain, neck pain, anterior spinal artery compression syndrome and Brown Sequard Syndrome/rare neurological syndrome characterized by a lesion in the spinal cord which results in weakness or paralysis/hemiplegia on one side of the body and loss sensation on the opposite side. Current Medications per the MRR included: Hydrocortisone ointment; Glycerin suppositories; Cyclobenzaprine; Cymbalta; Clonazepam; Docusate Sodium; Enemeez Mini edema; Hydrocodone; Lactulose liquid; Methadone; Nucynta; Prilosec; Senokot-S; and Topamax.

IMR ISSUES, DECISIONS AND RATIONALES

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

refill Prilosec 20 mg tablet by mouth daily as needed for heartburn from pain medications, dispense #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & Cardiovascular risk Page(s): 68.

Decision rationale: According to the California MTUS guidelines, patients that are over the age of 65 years, have a history of peptic ulcer, gastrointestinal (GI) bleeding or perforation, are concurrently using Aspirin, corticosteroids, and/or an anticoagulant, or are taking a high dose or multiple NSAID's are at risk for GI events. According to the records provided, the patient is not currently taking NSAIDs, or other drugs that have been documented to cause gastroesophageal reflux disease (GERD). Therefore, based on the California MTUS Guidelines and the medical records provided, the request is not medically necessary or appropriate.