

<b>Case Number:</b>	CM14-0101927		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	09/18/2007
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	06/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2014

### 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 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:

Medical records reflect the claimant is a 52-year-old who sustained a work injury on September 18, 2007. Office visit on April 23, 2014 notes the claimant continues with neck pain. The claimant is status post ACDF C5-C6 and C6-C7. The claimant is being treated with medications. Office visit on 7-29-14 notes the claimant reports her neck feels sore. She rates her pain as 9-10/10. She reports her right hand tingles more. The claimant is noted to have radiculopathy bilaterally at C5-C7. On exam, the claimant has tenderness to palpation, mild muscle spasms and residual right C7 radiculopathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anaprox 500 mg, sixty count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG reflect that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is an absence in documentation documenting medical necessity for the long

term use of an NSAID. There is no documentation of functional improvement with this medication. Therefore, the request for Anaprox 500 mg, sixty count is not medically necessary or appropriate.

**Prilosec 20 mg, thirty count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS GI symptoms Page(s): 67-73.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines notes that PPI (proton pump inhibitors) are indicated for patients with intermediate or high risk for GI events. There is an absence in documentation noting that this claimant has secondary GI effects due to the use of medications or that she is at an intermediate or high risk for GI events. Therefore, the request for Prilosec 20 mg, thirty count is not medically necessary or appropriate.