

<b>Case Number:</b>	CM14-0137359		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	09/24/2007
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Massachusetts. 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:

According to the documents available for review, the patient is a 42 year old female. The date of injury is September 24, 2007. Patient sustained an injury to the cervical spine. The exact mechanism of injury was not elaborated on in the notes available for review. The patient has numerous diagnoses including small hiatal hernia, mild chronic and acute gastritis, gastroesophageal reflux disease, and irritable bowel syndrome. The patient is maintained on the multimodal pain medication regimen including Protonix. A request for Protonix was denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Request for Protonix 20mg #90:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's, GI Symptoms & Cardiovascular Risk. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Workers' Compensation, Online Edition: Pain (PPI's)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPI Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Chronic, PPI.

**Decision rationale:** The MTUS makes the following recommendations for the use of proton pump inhibitors. Clinicians should weight the indications for Non-Steroid Anti-Inflammatory Drugs (NSAIDs) against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, Ibuprofen, Naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is Naproxyn plus low-dose aspirin plus a PPI. Cardiovascular disease: A non-pharmacological choice should be the first option in patients with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short term needs. An opioid also remains a short-term alternative for analgesia. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is Naproxyn plus low-dose aspirin plus a PPI. Mild to moderate risk factors: If long-term or high-dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If Naproxyn is ineffective, the suggested treatment is (1) the addition of aspirin to Naproxyn plus a PPI, or (2) a low-dose Cox-2 plus ASA (Acetyl Salicylic Acid). Additionally, according to the ODG, Chronic, pain section on PPI, these agents are recommended for patients at risk for gastrointestinal events. According to the records available for review the patient carries the following 4 gastrointestinal diagnoses; small hiatal hernia, mild chronic and acute gastritis, gastroesophageal reflux disease, and irritable bowel syndrome and is therefore at risk for ongoing gastrointestinal events. Thus, the requirements for treatment have been met and medical necessity has been established. Therefore, the request of retrospective Request for Protonix 20mg #90 is medically necessary and appropriate.