

<b>Case Number:</b>	CM14-0197326		
<b>Date Assigned:</b>	12/05/2014	<b>Date of Injury:</b>	05/05/2009
<b>Decision Date:</b>	01/20/2015	<b>UR Denial Date:</b>	11/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 36-year-old woman who sustained a work-related injury on May 5, 2009. Subsequently, she developed chronic back pain. Prior treatments included: medications, hot/ice packs, and exercises. According to a progress report dated October 29, 2014, the patient complained of back pain and sciatic pain. She described the pain as mild and moderate with radiation to both legs. On her follow-up visit of February 2012, he patient asked to be tapered off Norco, which was replaced by Tramadol. On a follow-up visit on August 27, 2014, the patient sated that Tramadol was no longer effective and wanted to return to Hydrocodone. Examination of the lumbar spine revealed the presence of paraspinal spasm. Trigger points present: sciatic right and left, iliac crest, and lumbar parspinals L4-5, bilaterally. Range of motion was 25% reduced. Sensory exam was normal. Motor exam was normal. Deep tendon reflexes were normal. The patient was diagnosed with lumbosacral radiculopathy on the right and lumbosacral DJD and degenerative disc disease. The provider requested authorization to use Vimovo.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Vimovo 500mg/20mg:** Upheld

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

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

**Decision rationale:** Vimovo is formed by esomeprazole and naproxen. According to MTUS guidelines, Omeprazole is indicated when non-steroidal anti-inflammatory drugs (NSAIDs) are used in patients with intermediate or high risk for gastrointestinal events. The risks for gastrointestinal events are: (1) age > 65 years; (2) history of peptic ulcer, gastrointestinal (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 acetylsalicylic acid (ASA)). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. There is no documentation that the patient has GI issue that requires the use of Prilosec. There is no documentation in the patient's chart supporting that she is at intermediate or high risk for developing gastrointestinal events. In addition, there is no controlled study supporting the superiority of the use of Vimovo to Naproxen and Omeprazol used separately. Therefore, Vimovo 500mg/20mg prescription is not medically necessary.