

<b>Case Number:</b>	CM14-0198171		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	07/18/2011
<b>Decision Date:</b>	01/27/2015	<b>UR Denial Date:</b>	10/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Texas & Florida. 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 50 year old male who was injured on 7/18/2011. The diagnoses are status post multiple bone fractures, thoracic spine fusion, cervical spine, thoracic spine and lumbar spine pain. The past surgery history is significant for multiple surgeries for injuries, thoracotomy, ORIF right femur, thoracic spine fusion and right shoulder surgery. The 2011 MRI of the right shoulder showed supraspinatus tendon tear and degenerative changes of the acromioclavicular joint. A 2014 EMG showed right S1 radiculopathy. [REDACTED], noted subjective complaint of pain located in the neck, upper back and low back. The upper back pain radiates around the chest wall. There is associated muscle spasm and dysesthesia over the thoracotomy scar. On 5/29/2014, [REDACTED] noted that the patient had symptomatic reflux and gastritis associated with the use of the pain medications. The medication listed is Norco, diclofenac and lidocaine gel. A Utilization Review determination was rendered on 10/29/2014 recommending non-certification for Protonix 20mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Protonix 20 mg:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 64. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter, Proton Pump Inhibitors

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that proton pump inhibitors can be utilized for the prophylaxis and treatment of NSAIDs associated gastritis during chronic NSAIDs treatment. The records indicate that the patient have documented history of GERD and gastritis that is worsened by the chronic use of diclofenac for the treatment of musculoskeletal pain. The records indicate that the Protonix is effective in the prevention of the NSAIDs associated gastrointestinal side effects. The criteria for the use of Protonix 20mg are met; therefore the request is medically necessary.