

<b>Case Number:</b>	CM15-0006747		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	11/26/2003
<b>Decision Date:</b>	04/03/2015	<b>UR Denial Date:</b>	12/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 injured worker is a 67-year-old male who reported injury on 11/26/2003. The mechanism of injury was not included. His diagnoses included low back pain with probable right sided lumbar radicular pain, lumbar disc degeneration L5-S1 with annular tear, right knee medial meniscus posterior horn tear status post arthroscopic surgery, right knee small osteochondral defect and posterior medial femoral condyle. The progress report dated 02/09/2015 documented the injured worker continued to have low back pain and right knee pain, some clicking along the right knee. The pain was worse at night, and with prolonged weight bearing he will start to limp. He has complaints of low back pain extending down the right leg. His medications included Protonix 40 mg and Mobic 7.5 mg. On physical exam, there was no swelling or erythema noted to the right knee. Tenderness was noted along the medial joint line.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Protonix 40mg #30 with 3 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Proton Pump Inhibitors.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS  
Page(s): 68, 69.

**Decision rationale:** The request for Protonix 40mg #30 with 3 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. Clinicians should determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.). There is no indication to provide refills of any medication without interval evaluation of its efficacy. There is a lack of documentation regarding a history of peptic ulcer, GI bleeding or perforation. As the injured worker appears to have no risk factor and no cardiovascular disease, the request for Protonix 40 mg #30 with 3 refills is not medically necessary.

**Mobic 7.5mg/tab #30 with 3 refills:** 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.

**Decision rationale:** The request for Mobic 7.5mg/tab #30 with 3 refills is not medically necessary. The California MTUS guidelines state NSAIDS are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. There is no indication to provide refills of any medication without interval evaluation of its efficacy. There is a lack of documentation regarding objective functional improvement with this medication and documented pain relief with this medication. Therefore, the request for Mobic 7.5 mg/tab #30 with 3 refills is not medically necessary.