

Case Number:	CM15-0181695		
Date Assigned:	09/23/2015	Date of Injury:	02/26/2015
Decision Date:	11/03/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/15/2015

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
 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 59 year old male who sustained an industrial injury on February 26, 2015. A recent primary treating office visit dated April 21, 2015 reported subjective complaint of constant low back pain that is radiating down the left leg to the bottom of the foot. There is muscle spasms and tingling. Objective findings showed "tender over posterior superior iliac spine, left. The worker was diagnosed with musculoligamentous sprain of the lumbar spine with lower extremity radiculitis. The plan of care noted: continuing with Tramadol, Zolpidem, Orphenadrine, Naproxen, Omeprazole, Colace, Celecoxib, Hydrocodone, and Flexeril: complete physical therapy session, and pending magnetic resonance imaging authorization. He was administered an injection of Toradol. A Doctors' first report of illness dated March 03, 2015 reported subjective complaint of "constant low back pain" "described as "a sharp, burning and stabbing sensation." "There is numbness and tingling on the front and back of the left thigh." The patient also has burning on the bilateral lower back. Treatment rendered to include: continuing with Tramadol, Zolpidem, Orphenadrine, Naproxen, Omeprazole, Colace, and Celecoxib, Hydrocodone, and Flexeril; continue with physical therapy. Further treatment required to involve: diagnostic testing magnetic resonance imaging, nerve conduction, radiography, durable medical equipment, injections, and surgery. On August 11, 2015 a request was made for Protonix 20mg #60 which was noted with denial due to evidence provided offered no concise clear defined rationale for the medical necessity of this medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Protonix 20mg #60 (DOS 8/3/25): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The patient presents with low back pain. The request is for RETROSPECTIVE PROTONIX 20MG #60 (DOS 8/3/15). Physical examination to the lumbar spine on 04/21/15 revealed tenderness to palpation over the left posterior superior iliac spine. Per 03/11/15 progress report, patient's diagnosis includes back pain, strain. Patient's medications, per 04/21/15 progress report include Tramadol, Celebrex, Ambien, Naproxen, Orphenadrine, Omeprazole and Lipitor. Patient's work status is regular duties. MTUS Chronic Pain Medical Treatment Guidelines, page 69 under NSAIDs, GI symptoms & cardiovascular risk Section states, "Recommend with precautions as indicated below: Clinicians should weight the indications for 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 ug 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. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007) The treater has not specifically discussed this request. In regard to the request for Protonix, the treater has not included GI assessment or complaints of GI upset to substantiate such a medication. Although it is indicated that the patient is utilizing Naproxen (an NSAID), there is no discussion of gastric complaints or evidence of prior GI symptom relief owing to PPI utilization. Without an appropriate GI assessment or evidence of dyspepsia secondary to NSAID utilization, this medication cannot be substantiated. Therefore, the request IS NOT medically necessary.