

<b>Case Number:</b>	CM15-0213261		
<b>Date Assigned:</b>	11/03/2015	<b>Date of Injury:</b>	08/30/2011
<b>Decision Date:</b>	12/18/2015	<b>UR Denial Date:</b>	10/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2015

### 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 33-year-old female, with a reported date of injury of 08-30-2011. The diagnoses include post-traumatic stress disorder, post-concussion syndrome, sprain of ligaments of lumbar spine, and tension-type headaches. The medical report dated 10-09-2015 indicates that the injured worker continued to have ongoing chronic neck and upper back pain and some lower back pain. She also had frequent headaches. The injured worker rated her neck pain 4 out of 10, and her lower back pain 5-9 out of 10. It was noted that the injured worker complained of nausea, but denied constipation, heartburn, abdominal pain, black tarry stools, or throwing up blood. The objective findings include tenderness to palpation of the posterior cervical paraspinal muscles without evidence of gross muscle spasm; tenderness to palpation of the low lumbar paraspinal muscles from L3 through L5; some tenderness to palpation over the thoracic paraspinal muscles from the possible levels of T1 through T4; pain in the lower legs with straight leg raise; and an non-antalgic gait. It was noted that the injured worker was not permanent and stationary. The diagnostic studies to date have included a urine drug screen on 07-07-2015 which was positive for opiates. Treatments and evaluation to date have included Protonix (since at least 03-2015), Lexapro, Meloxicam, Norco, Nortriptyline, physical therapy, Ibuprofen, and cognitive behavioral therapy. The request for authorization was dated 10-21-2015. The treating physician requested Protonix DR 20mg #60 with five refills, to be taken 30 minutes prior to taking Meloxicam. On 10-28-2015, Utilization Review (UR) non-certified the request for Protonix DR 20mg #60 with five refills.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Protonix DR 20mg #60 with 5 refills:** Upheld

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

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

**Decision rationale:** The patient was injured on 08/30/11 and presents with pain in her neck, upper back, and lower back. The request is for PROTONIX DR 20 MG #60 WITH 5 REFILLS. The RFA is dated 10/21/15 and the patient is not permanent and stationary. MTUS guidelines, NSAIDs GI symptoms & cardiovascular risk section, page 68 states that omeprazole is recommended with precaution for patients at risk for gastrointestinal events: 1. Age greater than 65. 2. History of peptic ulcer disease and GI bleeding or perforation. 3. Concurrent use of ASA or corticosteroid and/or anticoagulant. 4. High dose/multiple NSAID. MTUS continues to state, NSAIDs, GI symptoms, and cardiovascular risks: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2 receptor antagonist or a PPI. The patient is diagnosed with post-traumatic stress disorder, post-concussion syndrome, sprain of ligaments of lumbar spine, and tension-type headaches. As of 09/09/15, the patient is taking Lexapro, Meloxicam, Norco, and Nortriptyline. In this case, the patient is not over 65, does not have a history of peptic ulcer disease and GI bleeding or perforation, does not have concurrent use of ASA or corticosteroid and/or anticoagulant, and does not have high-dose/multiple NSAID. The treater does not document dyspepsia or GI issues. Routine prophylactic use of PPI without documentation of gastric issues is not supported by guidelines without GI risk assessment. Given the lack of rationale for its use, the requested Protonix IS NOT medically necessary.