

<b>Case Number:</b>	CM14-0162139		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	02/11/2006
<b>Decision Date:</b>	12/15/2014	<b>UR Denial Date:</b>	09/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in New York. 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 injured worker is a 46-year-old female who reported an injury on 02/11/2006. Her diagnoses were noted to include knee tendinitis/bursitis, lumbosacral radiculopathy, and cervical strain/sprain. Past treatments were noted to include physical therapy and activity restrictions. The diagnostic studies were not provided. Her surgical history was noted to include 3 unspecified lumbar spine surgeries on unspecified dates. On 08/14/2014, the injured worker reported pain in her lower back that radiated down into her lower extremities with numbness and weakness. She rated this pain to be 7/10 to 8/10. The objective findings revealed tenderness and spasm of the paravertebral musculature of the cervical and lumbar spine with a decreased range of motion. Also noted was decreased sensation over the L5 dermatomes bilaterally with pain. Current medications were noted to include Gabapentin, Norco, Prilosec, and Prozac. The treatment plan was noted to include refills for Prilosec to be used as needed for stomach protection and gastritis, as well as a 6 month supply to prevent disruption of treatment. The Request for Authorization form was submitted for review on 08/19/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prilosec 20 mg #60 with five (5) 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 (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs  
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**Decision rationale:** The request for Prilosec 20 mg, #60 with 5 refills, is not medically necessary. The California MTUS Guidelines recommend proton pump inhibitors for patients at risk for gastrointestinal events. The documentation submitted did indicate a history of gastroesophageal reflux disease that is exacerbated with medications and adequately managed by Prilosec. The documentation also indicated that the medication efficacy would be assessed. However, the request for 5 refills would not be indicated, as the frequency of assessments to allow for periodic reassessment of medication efficacy was not provided in the documentation submitted. Furthermore, a frequency in which the medication was prescribed was not provided. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the request for Prilosec 20 mg, #60 with 5 refills, is not medically necessary.