

<b>Case Number:</b>	CM13-0062801		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	04/17/2001
<b>Decision Date:</b>	03/13/2015	<b>UR Denial Date:</b>	11/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### 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, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care Medicine

### 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 40-year-old female who reported an injury on 04/19/2001. The mechanism of injury was not stated. The current diagnoses include lumbar radiculopathy, lumbar disc degeneration, lumbar failed surgery syndrome, status post lumbar fusion, complex regional pain syndrome in the right upper extremity, chronic pain, right shoulder pain, failed spinal cord stimulator trial, and status post right shoulder surgery. The injured worker presented on 10/09/2013 with complaints of low back pain with radiation into the bilateral lower extremities. Upon examination, there was limited lumbar range of motion secondary to pain, spinal vertebral tenderness, lumbar myofascial tenderness, paraspinous muscle spasm, decreased sensation in the right upper extremity, moderately decreased motor strength in the right upper extremity, right shoulder tenderness with positive allodynia, and decreased right shoulder range of motion. The recommendations included continuation of the current medication regimen. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PANTOPRAZOLE 20MG 1 TAB BID 30 DAYS #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI SYMPTOMS AND CARDIOVASCULAR RISK Page(s): 68-69.

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

**Decision rationale:** California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factors and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. There was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the injured worker does not meet the criteria for the requested medication. As such, the request is not medically appropriate at this time.