

Case Number:	CM14-0210103		
Date Assigned:	12/23/2014	Date of Injury:	06/15/2013
Decision Date:	02/28/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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: Preventive Medicine, Occupational 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:

Patient is a 56 year-old female with date of injury 06/15/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 10/29/2014, lists subjective complaints as pain in the low back. Objective findings: Examination of the lumbar spine revealed tenderness to palpation over the upper, mid and lower paravertebral muscles. Range of motion as restricted in all planes with increased pain with flexion and extension. Straight leg raise and rectus femoris stretch sign did not demonstrate any nerve irritability. There was patchy decreased sensation in the bilateral lower extremities, right more so than left, in the L5 and S1 distribution. Diagnosis: 1. Lumbar spine strain 2. Lumbar radiculopathy 3. Degenerative joint disease of the lumbar spine with protrusion at L1, L2, L3, L4, and L5-S1. The medical records supplied for review document that the patient has been Protonix for at least as far back as four months. The Anaprox and Tylenol #3 were first prescribed on the date of the request for authorization on 10/29/2014. Medication: 1. Anaprox 550mg, #60 SIG: one tablet two times daily 2. Protonix 20mg, #30 SIG: one tablet once a day 3. Tylenol #3, #60 SIG: one tablet every 4-6 hours.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox 550mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. This appears to be a new prescription and a first trial for this patient. I am reversing the previous utilization review decision. Anaprox 550mg #60 is medically necessary.

Protonix 20mg #30: Upheld

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

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (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. Although there is documentation of gastritis, there is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor Protonix. Protonix 20mg #30 is not medically necessary.

Tylenol #3 #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 35.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that codeine is recommended as an option for mild to moderate pain. Review of the records reveals no indication the patient has had problems with narcotics in the past and that she does suffer from mild to moderate pain. I am reversing the previous utilization review decision. Tylenol #3 #60 is medically necessary.