

Case Number:	CM14-0218253		
Date Assigned:	01/07/2015	Date of Injury:	12/23/2011
Decision Date:	03/04/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/30/2014

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: New Jersey, New York
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 46 year old injured worker (IW) continues to complain of low back pain stemming from a work related injury reported on 12/23/2011. In the progress notes, dated 11/19, note this IW to be on multiple medications, to include Fenoprofen which states significant side effects to the stomach or the bowel, such as ulcers and bleeding. Zantac, or Ranitidine, 150mg twice a day was recommended and ordered for stomach protection. She was diagnosed with lumbar strain, lumbar degenerative disc disease, and myofascial pain. On 12/3/2014 Utilization Review (UR) non-certified, for medical necessity, the request for Ranitidine 150 mg #60 stating that no gastrointestinal distress or risk factors were documented to warrant authorization for this medication, and therefore do not meet the criteria set forth by Integrated Treatment/Disability Duration Guidelines on chronic pain; as MTUS ACOEM guidelines are silent on this issue.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pharmacy purchase of Ranitidine 150mg #60: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Treatment Integrated Treatment/Disability Duration Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The request is considered medically necessary. The UR claimed that there was no documentation of gastrointestinal distress. However, the chart describes the patient has having gastric irritation which was improved with Ranitidine. The patient was on Fenoprofen, an NSAID, that carries the risk of gastritis and gastrointestinal bleeding. It is reasonable to prescribe an H2 blocker for dyspepsia due to NSAID use according to MTUS guidelines. Therefore, I am reversing the UR decision and the use of ranitidine is considered medically necessary.