

<b>Case Number:</b>	CM15-0113235		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	04/24/2002
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	06/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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, Pain Management

### 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 67 year old male sustained an industrial injury on 4/24/02. He subsequently reported Diagnoses include lumbar degenerative disc disease. Treatments to date include x-ray and MRI testing and prescription pain medications. The injured worker continues to experience low back pain with intermittent radiation to the bilateral lower extremities. Upon examination, there was tenderness to palpation throughout the lumbar spine. Motor testing in the lower extremities was 5/ 5 in all major muscle groups. Deep tendon reflexes in the lower extremities were 2 plus/ 4 and symmetrical bilaterally. There was some paresthesias noted in the L5 distribution of the right lower leg. Straight leg raise testing was negative bilaterally. A request for Ranitidine HCL 150mg #60 with 2 refills for DOS 5/21/15 and Ranitidine HCL 150mg #60 for DOS 4/23/15 was made by the treating physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ranitidine HCL 150mg #60 with 2 refills for DOS 5/21/15:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69 of 127.

**Decision rationale:** Regarding the request for ranitidine (Zantac), California MTUS states that H2 receptor antagonists are appropriate for the treatment of dyspepsia secondary to NSAID therapy. Within the documentation available for review, there is indication that the patient has complaints of dyspepsia secondary to NSAID use that have responded positively to the use of ranitidine. In light of the above, the currently requested ranitidine (Zantac) is medically necessary.

**Ranitidine HCL 150mg #60 for DOS 4/23/15:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68-69 of 127.

**Decision rationale:** Regarding the request for ranitidine (Zantac), California MTUS states that H2 receptor antagonists are appropriate for the treatment of dyspepsia secondary to NSAID therapy. Within the documentation available for review, there is indication that the patient has complaints of dyspepsia secondary to NSAID use that have responded positively to the use of ranitidine. In light of the above, the currently requested ranitidine (Zantac) is medically necessary.