

Case Number:	CM13-0065174		
Date Assigned:	01/03/2014	Date of Injury:	11/05/2007
Decision Date:	05/12/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/12/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation has a subspecialty in Pain Medicine and is licensed to practice in California. 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 reported a date of injury of November 5, 2007. The diagnoses include chronic low back pain, lumbar radiculopathy, hypertension, and diabetes that is poorly controlled. The patient has been certified for 2 transforaminal epidural steroid injections. The provider has requested consultation with internal medicine for clearance for the lumbar epidural steroid injection. The utilization review determination noncertified the request for Prilosec and internal medicine consultation. The stated rationale for the noncertification of the internal medicine consultation was that lumbar epidural steroid injections do not affect glycemic control based upon a 2011 study. With regard to Prilosec, it was noted that this medication has been prescribed since January 21, 2013. The patient originally had gastric upset at that time, but since then has had discontinuation of Motrin 800 mg. Subsequent reporting fails to document any gastrointestinal risk factors.

IMR ISSUES, DECISIONS AND RATIONALES

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

REQUEST FOR 1 INTERNAL MEDICINE CLEARANCE PRIOR TO LESI: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation California Official Medical Fee Schedule, 1999 edition, Surgery General Information and Ground Rules, page 92- 93

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 127.

Decision rationale: The California Medical Treatment and Utilization Schedule do not have specific guidelines with regard to consulting specialists. American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, Second Edition states the following on page 127: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. When a physician is responsible for performing an isolated assessment of an examinee's health or disability for an employer, business, or insurer, a limited examinee-physician relationship should be considered to exist." In the case of this injured worker, the diabetes and hypertension are not industrially related. There is no documentation that the patient requires sedation during the transforaminal epidural steroid injections. The patient should have management of his nonindustrial diagnoses by a non- Worker's Compensation provider already. Although steroids can elevate low pressure and temporarily increase blood sugars, lumbar epidural steroid injections are not a contraindication for patients. An internal medicine consultation is not typically required. The injured worker should have follow-up with his non-Worker's Compensation provider for routine management of diabetes and hypertension. This request is not recommended.

PROSPECTIVE REQUEST FOR 1 PRESCRIPTION OF PRILOSEC 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): 68-69.

Decision rationale: The Chronic Pain Medical Treatment Guidelines on page 68-69 states the following regarding the usage of proton pump inhibitors (PPI): "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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 (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. Recommendations Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non- selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or misoprostol (200 µg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" In the case of

this injured worker, there is documentation that the patient has no history of peptic ulcer disease in a pain management consultation on date of service of August 28, 2013. The patient's is taking hydrocodone and is not on any nonsteroidal anti-inflammatory drugs at this time. Given the lack of documentation of gastrointestinal risk factors, this request is recommended for noncertification.