

<b>Case Number:</b>	CM14-0108739		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	05/13/2013
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2014

### 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. The expert reviewer is Board Certified in Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 has 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:

This patient is a 50-year-old employee with date of injury of May 13, 2013. Medical records indicate the patient is undergoing treatment for gastroesophageal reflux disease (GERD), chronic low back pain; cervical spine radiculopathy; lumbar spine radiculopathy; left foot drop; spinal cord compression; cervical intervertebral disc (IVD) C5-C6 and C6-C7 with myelopathy; cervicobrachial syndrome; cervical degenerative disc disease C5-C6 and C6-C7; essential hypertension; tension headache; unspecified bowel problems; benign prostatic hyperplasia (BPH); status post shoulder surgery and cervical stenosis at C5-C6 and C6-C7. Subjective complaints include neck pain that radiates and is rated as a 4-6/10 on the pain scale. Sitting tolerance is one hour and walking tolerated for 30 minutes. He has greater weakness in his left arm than his right arm. Objective findings include ataxia on heel to toe gait; 4/5 strength of left dorsal intrinsic muscles, left wrist extensors and left triceps, decreased sensation of cervical spine, decreased left lateral rotation, positive Spurling's on his left. He has absent bilateral reflexes in the upper and lower extremities and decreased sensation in C6, C8 and T1 dermatomes. Treatment has consisted of Percodan, aspirin, Aleve, hydrochlorothiazide, tramadol and omeprazole. As of June 2014, the patient was not in physical therapy, although it had been recommended. The utilization review determination was rendered on July 7, 2014 recommending non-certification of Omeprazole (20mg, #60 with two refills); Decision for somatosensory evoked potentials (SSEP) studies and pre-operative lab work.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole (20mg, #60 with 2 refills): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** MTUS states, "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)." And, "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 g 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)." The medical documents provided do not establish the patient has having documented GI bleeding, perforation, peptic ulcer, high dose NSAID, or other GI risk factors as outlined in MTUS. As such, the request for Omeprazole 20mg #60 with 2 refills is not medically necessary.

**Somatosensory Evoked Potentials (SSEP) Studies: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, SSEP and Evoked potential studies.

**Decision rationale:** ODG states, "Recommended as a diagnostic option for unexplained myelopathy and/or in unconscious spinal cord injury patients. Not recommended for radiculopathies and peripheral nerve lesions where standard nerve conduction velocity studies are diagnostic. (Aetna, 2006) Evoked potentials are the electrical signals generated by the nervous system in response to sensory stimuli. Somatosensory evoked potentials (SSEPs) are used for clinical diagnosis in patients with neurologic disease for prognostication in comatose patients. Fewer diagnostic SSEP studies are being performed now than in the pre-MRI era." The patient has had extensive electrodiagnostic studies, MRIs and is awaiting cervical spine artificial disk replacement. The treating physician has not provided medical documentation to meet ODG guidelines for an SSEP at this time. As such, the request for SSEP is not medically necessary.

**Pre-Operative Lab Work: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Preoperative lab testing.

**Decision rationale:** ODG states that, "preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. (Feely, 2013) (Sousa, 2013)." The treating physician did not provide an established surgery date and an order for preoperative clearance from the operating surgeon. As such the request for Pre-op Lab Work is not medically necessary at this time.