

Case Number:	CM14-0115639		
Date Assigned:	08/04/2014	Date of Injury:	11/01/2011
Decision Date:	09/10/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/24/2014

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 Anesthesiology, has a subspecialty in Acupuncture & 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 claimant is a 38-year-old male injured worker with date of injury of 11/1/11, with related left foot pain. Per progress report dated 2/6/14, he rated his foot pain as 3/10 at the least and 9/10 at the worst, with an average of 8/10. He stated there is associated burning, electric-like shock, tingling, stabbing and prickling sensation, radiating distally from the ankle to the toes. He states that symptoms are severe during the night due to neurotic pain, and during the day after walking. He also complained of headaches, stress, anxiety, weight gain, and balance problems. He has been treated with physical therapy, acupuncture, chiropractic manipulation, and medication management. The date of UR decision was 7/1/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole DR 20mg Capsule, as prescribed (SIG) #30 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an

H2-receptor antagonist or a proton pump inhibitor (PPI). The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age greater than 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of aspirin (ASA), corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose (ASA). The Chronic Pain Medical Treatment Guidelines further specify, 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 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). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI, only 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 gastrointestinal (GI) risk, the suggestion is Naprosyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007). The documentation submitted for review details a history of dyspepsia secondary to medication usage, however, per the latest progress reports, dyspepsia was not a current problem, nor was there documentation of therapy with an NSAID. The request is not medically necessary.