

<b>Case Number:</b>	CM14-0159929		
<b>Date Assigned:</b>	10/03/2014	<b>Date of Injury:</b>	08/24/2001
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 Physical Medicine & Rehabilitation 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 is a 48-year-old male who reported an injury on 08/24/2001 due to an unknown mechanism. Diagnoses were chronic low back pain with a flare-up of muscle spasms, SI joint impingement on the right side with frequent flares. Physical examination on 08/25/2014 revealed complaints of ongoing low back pain. It was reported that the injured worker had severe lower back pain, which was increased with prolonged standing and sitting, as well as repetitive bending activities with the lower back. Examination revealed anterior right sided pain of the lower back. There was tenderness to palpation at the SI joint posteriorly. There was positive straight leg raise on the right with some tenderness and decreased range of motion of the lumbar spine. The rationale and Request for Authorization form were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole 20 mg, QTY: 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs) GI (Gastrointestina.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The decision for Omeprazole 20mg QTY: 60 is not medically necessary. Clinicians should determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. 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 (200g 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. The efficacy for this medication was not reported. The request does not indicate a frequency for the medication. There was no diagnosis of a GI event to support the use. Therefore, this request is not medically necessary.

**Naproxen 550 mg, QTY: 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**Decision rationale:** The decision for Naproxen 550 mg, quantity 90 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDs are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. There was no documentation of objective functional improvement and objective decrease in pain. Therefore, this request is not medically necessary.

**Hydrocodone/APAP 10/325 mg, QTY: 90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen Page(s): 91.

**Decision rationale:** The decision for Hydrocodone/APAP 10/325 mg, quantity 90 is not medically necessary. The California Medical Treatment Utilization Schedule states Hydrocodone/Acetaminophen is indicated for moderate to moderately severe pain and there should be documentation of the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. The 4 A's for ongoing monitoring of an opioid medication was not reported. The request does not indicate a frequency

for the medication. The clinical information submitted for review does not provide evidence for continued use of this medication. Therefore, this request is not medically necessary.