MAXIMUS Federal Services

Case Number:	CM14-0059731		
Date Assigned:	07/09/2014	Date of Injury:	03/25/2013
Decision Date:	09/17/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/30/2014

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 Family 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:

This 40-year old man apparently injured his low back on 3/25/13. There is no documentation in the available records regarding the mechanism of injury, and little documentation as to what has occurred since the date of injury. Current diagnoses include degenerative lumbosacral intervertebral disease with R leg radiculopathy, and facet arthrosis with spinal stenosis. Treatment has included medications including opioids and ibuprofen, as well as two epidural steroid injections. There is a single progress note from the primary treater in the records, dated 10/28/13. In it he states that the patient received significant benefit from his second epidural steroid injection done 9/24/13. The patient was taking Percocet, Neurontin, Flexeril, Prilosec, Motrin and Trazodone at the time of the visit. The primary treater added MS Contin to this regimen, because it was no longer controlling the patient's pain. The treater requested authorization for a third epidural steroid injection at this visit. It was initially denied in UR, but then approved. Apparently the primary treater re-evaluated the patient on 1/15/14 and requested Prilosec delayed release 20 mg #30 with three refills. This request was reviewed and denied in UR. The reviewing physician makes reference to progress notes dated 1/15/14 and 2/14/14, as well as requests for authorization generated on the same two dates. None of these records are available in those provided for the current IMR. The reviewing physician describes having a conversation with the primary treater on 4/10/14 in which the treater stated that the patient was doing very well, improving functionally, and having no medication side effects. The reviewing physician recommended non-certification of the request for Prilosec on 4/11/14. A request for IMR for this decision was made 4/28/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #30 times 3 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Up-to-Date, an evidence-based online review service for clinicians, online (up-to-date.com), Omeprazole: drug information.

Decision rationale: The first guideline cited above states that clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. They should determine if the patient is at risk for GI events. Risk factors include age over 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of aspirin, corticosteroids, or an anticoagulant; or high-dose or multiple NSAIDs, or an NSAID combined with aspirin. Patients with no GI risk factors and no cardiovascular disease may be prescribed a non-selective NSAID. Those at intermediate risk for GI disease should receive a non-selective NSAID plus a proton pump inhibitor (PPI) or misoprostol; or a Cox-2 selective NSAID. Patients at high GI risk should receive a Cox-2 selective NSAID and a PPI if an NSAID is absolutely necessary. This reference notes that long-term PPI use has been shown to increase the risk of hip fracture. The Up-to-Date reference cited above lists the indications for omeprazole as: active duodenal ulcer, gastric ulcer, erosive esophagitis, helicobacter pylori eradication, pathological hypersecretory conditions (such as Zollinger-Ellison syndrome), frequent heartburn, GERD or other acid-related disorders, NSAID-induced ulcer treatment, NSAID-induced ulcer prophylaxis, and stress ulcer prophylaxis in ICU patients. The last three indications are off label. Risks of long-term use (usually over one year) include atrophic gastritis, increased incidence of gastric carcinoid tumors, clostridium difficile-associated diarrhea, increased incidence of osteoporosis-related fractures of the hip, spine, or wrist; hypomagnesemia and Vitamin B12 deficiency. Prilosec is brand-name Omeprazole, which is a proton pump inhibitor. It is impossible to guess from the available clinical records why omeprazole is being prescribed for this patient. There is no documentation of his risk for GI events. There is no documentation of any condition likely to require a PPI prescription, or of any symptoms suggestive of such a condition. It does appear likely that the patient has been taking Prilosec for at least a year, which would put him at risk for the side effects listed above, many of which could be life threatening. Based on the evidence-based references cited above and the available clinical information, Prilosec is not medically necessary because there is no documentation of any possible benefit to the patient that is likely to outweigh its risks.