

<b>Case Number:</b>	CM14-0089452		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	01/23/2012
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	06/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/13/2014

### 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 and 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 58-year-old male who sustained an injury on 01/23/12. He complained of right knee pain. The pain was intermittent in frequency and moderate in intensity. His average level of pain in last one week was 2/10. Pain was described as sharp and electric like with pins and needles sensation. On exam, crepitus was noted in bilateral knees. Right knee MRI done on 05/13/13 revealed progression of the patellar chondral thinning laterally with development of a small area of mild subchondral cystic change, edema inferolaterally and chondral thinning and fraying in the medial and lateral compartments not significantly changed. He underwent right knee chondroplasty medial femoral condyle, patella and trochlea and excision of multiple loose bodies on 06/28/12. Current medications include Diclofenac XR 100 mg and Prilosec 10 mg. He was to continue home exercises - strengthening and conditioning and aqua therapy. He had attended acupuncture treatments four times in 2013, which provided him moderate relief. He had status post hyaluronic acid injections with some relief. On 01/13/14 he reported frequent heartburn. On 02/10/14 and 03/10/14 he reported no bowel or bladder problems. Prilosec 20 mg p.o. b.i.d. #60 was prescribed and dispensed on 02/10/14, 03/10/14, and 04/07/14. On 07/14/14, he was recommended to discontinue analgesic medications. Diagnosis: Tear of meniscus of knee. The request for Prilosec 20 mg #60 was denied on 06/11/14 due to lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gastrointestinal Events (2009) Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-69.

**Decision rationale:** The CA MTUS guidelines state PPI medications such as Omeprazole (Prilosec) may be indicated for patients at risk for gastrointestinal events, which should be determined by the clinician: 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). The guidelines recommend GI protection for patients with specific risk factors; however, the medical records do not establish the patient is at significant risk for GI events. Treatment of dyspepsia secondary to NSAID therapy recommendation is to stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. In this case, the IW was noted to have complained of heartburn on 1/13/14 and thus was placed on Prilosec. Nonetheless, discontinuation of NSAID was previously recommended. Moreover, there is no documentation of switching to a different NSAID to eliminate the need for GI protection. Also, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. Therefore, the medical necessity of Prilosec has not been established.