

Case Number:	CM14-0192038		
Date Assigned:	11/25/2014	Date of Injury:	02/09/2012
Decision Date:	02/09/2015	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/17/2014

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 New York. 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 injured workers DOI is listed as 9February 09, 2012; however, it stems back to an injury listed as August 01, 2010 where she got twisted folding a sheet and fell forward as a period covering February 19, 2011 to February 19, 2012 consisting of multiple issues attributable to continuous and repetitive heavy work. Her orthopedic complaints were initially related to her right wrist and elbow, right shoulder and neck as well as headaches attributed to the neck pain. She has seen multiple providers and undergone multiple investigations. MRI of the C spine did not reveal any central spinal stenosis or foraminal narrowing or impingement on cervical nerve roots. MRI of the shoulder revealed only A-C OA (osteoarthritis). MRI of the wrist and elbow were unremarkable. EMG of the bilateral UE were unrevealing. Neck pain was quantified as 7/10, right wrist at 9/10, right shoulder at 8/10 right elbow at 7/10. During this time she remained off work and reported experiencing GI problems with central epigastric pain, heartburn and acid reflux into her mouth as well as difficulty with slow transit of food from her chest to her stomach. She additionally experience symptoms of anxiety, depression, fatigue, sleeplessness and excessive worry about her finances that resulted in a psychiatric review and initiation of treatment. During this time she had been treated with NSAID's to include Naproxen and Motrin. A note December 12, 2012 from an internist indicated that Naproxen was discontinued and Tylenol #3 substituted because of the GI symptoms. She had been on daily Prilosec, apparently without relief. Notes from a treating orthopod covering March 28, 2013 through July 19, 2013 indicated the member was taking Motrin but did not mention Tylenol #3. An AME March 28, 2014 noted that her GI symptoms while on treatment for her pain management and consisted specifically of midline abdominal pain as well as heartburn, acid reflux into her chest and throat and complaints of poor transit time for food passing from the chest to the stomach. At that , medications included Omeprazole, Temazepam, Codeine, Ibuprofen, Cyclobenzaprine,

Carisoprodol, Ventolin (for asthma) and OTC Excedrin for her headaches. It was noted that no specific workup had been accomplished for her ongoing GI complaints. Of note, serology accomplished for H. pylori was noted to be markedly positive. Her GI complaints were noted to be subjective as there had been no formal evaluation and validation despite continued use of a PPI for over a year.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg quantity 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk, opioids Page(s): 68-6, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UpToDate - NSAID GI and Renal Toxicities accessed 11Dec14

Decision rationale: Per guidelines, the risk for the development of significant nonsteroidal anti-inflammatory drug (NSAID)-induced gastrointestinal bleeding or perforation due to a peptic ulcer has been evaluated in multiple studies. An important determinant is the duration of therapy. Administration of NSAIDs for a short period of time (less than one week) in healthy people is unlikely to result in any clinically significant gastroduodenal toxicity. Longer duration of therapy is associated with an increased risk of developing complications. On the other hand, gastroduodenal complications are most common within the first three months after the initiation of therapy. In planning for consideration of the use of PPI's, it is important to determine if the patient is at risk for gastrointestinal events such as the concurrent use of ASA, corticosteroids, and/or an anticoagulant (this patient has had prednisone to treat asthma exacerbations) or high dose/multiple NSAID (currently using Ibuprofen and Excedrin primarily for her headaches approximately 3 times a week). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions (but she does have markedly positive serology for H. pylori). Note that Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44) so assessing the underlying pathology of her continuing GI complaints becomes more pressing in this circumstance. It is unclear to what extent, if any, the use of a PPI has moderated her symptoms. The AME has indicated that her GI complaints relate to her ongoing orthopedic complaints and therefore has an attribution to her WPI of 25%. As a result, she continues to require treatment of her GI complaints. In order to move forward with management, and bearing in mind the failure of long term use of a PPI to control the symptoms, she ran appropriate evaluation to include at the least direct endoscopy and further examinations as felt warranted by a qualified Gastroenterologist. The differential in the face of these ongoing symptoms apart from simple GERD include esophageal dysmotility, esophageal spasm, esophageal stricture or Barrett's Esophagus (that case precede the development of esophageal carcinoma). The request is not medically necessary.