

Case Number:	CM14-0207101		
Date Assigned:	12/19/2014	Date of Injury:	02/03/2007
Decision Date:	02/13/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/10/2014

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 Practice, 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 46-year-old construction worker reported an injury to his low back due to slipping and falling while moving materials on a snow-covered roof on 2/3/07. He subsequently reported psychiatric problems due to his physical symptoms. There is little information in the available records in regards to the early treatment of his injuries. The earliest available note is a psychiatric QME report dated 2/18/14 which lists the patient's medications as gabapentin 600 mg 3 times/day, MS-Contin 15 mg 2 times/day, amitriptyline 75 mg at bedtime, fluoxetine 40 mg per day, and omeprazole 20 mg, frequency not specified. The most recent progress note in the records is from the patient's primary treater. It states that the patient has more pain (5/10) in the mornings due to cold weather. Documented physical findings include vital signs and oxygen saturation, and a statement that the patient is alert and oriented, well developed, and in no acute distress. There are no other documented physical findings, and no review of systems is documented. Current medications include gabapentin 600 mg 3 times per day, amitriptyline 75 mg 2 times/day, omeprazole 20 mg once per day, and fluoxetine 20 mg, 2 every morning. Diagnoses include recurrent major depression, lumbar radiculopathy, and lower back pain. The plan includes continuing extended release morphine 10 mg 3 times/day. This medication was dispensed in the office. Follow up at 3 months was planned. The patient is not working and has not worked since his injury as far as I am able to determine. An 11/14/14 request for authorization from the primary treater states that the patient is medically managed with gabapentin, amitriptyline, fluoxetine, and omeprazole (for GI protection with higher risk meds). The request for omeprazole was non-certified in UR on 11/26/14 on the basis that its use was not supported by MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #30: Upheld

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

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: UptoDate, an evidence-based online review service for clinicians, (www.uptodate.com) , Omeprazole: drug information.

Decision rationale: Omeprazole is a proton pump inhibitor (PPI). 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 UptoDate 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. Significant side effects include hepatic disease and hepatic failure. Risks of long-term (usually over one year) use 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. The clinical documentation in this case does not support the provision of omeprazole to this patient. The provider's stated rationale, that it is being prescribed for GI protection with higher risk meds, does not make sense since the patient is not taking an NSAID or another medication that puts him at high risk for GI events. The records do not contain documentation of symptoms of gastritis or of an assessment of the patient's risk factors for GI events. There is no documentation of any concern for another diagnosis that would require the use of a PPI. The patient has been taking omeprazole for at least 9 months, and probably for over a year. This long-term use puts him at increased risk for the side effects described above, some of which may be life threatening. Based on the clinical information provided for my review and the evidence-base citations above, omeprazole 20 mg #30 is not medically necessary. It is not medically necessary because the provider has not documented symptoms compatible with any condition that would require its use, because the provider has not documented any risk factors for GI events that would require its use, and because its long-term use puts the patient at unacceptable risk for serious side effects.

