

<b>Case Number:</b>	CM14-0084357		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	02/02/2013
<b>Decision Date:</b>	01/20/2015	<b>UR Denial Date:</b>	05/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2014

### 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 is a 44 year-old female worker who was injured when a vehicle was rear-ended in a motor vehicle accident. She was pushed forward and the seat belt pulled tight. The date of injury was February 2, 2013. Diagnoses include cervical radiculopathy, shoulder impingement and lumbar radiculopathy. On April 29, 2014, the injured worker complained of continuous neck pain, right shoulder pain and lower back pain. The pain caused her difficulty with activities of daily living. Physical examination revealed tenderness to palpation and spasm present in the paraspinal muscles. Treatment modalities included medications, chiropractic care, aquatic therapy and acupuncture. In report dated February 13, 2014, notes stated that she was seen by a chiropractor and a course of pool therapy was provided. She continued to work regular duties and her symptoms progressively increased. A request was made for omeprazole 20 mg #30. On May 14, 2014, utilization review denied the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole (Prilosec) 20 mg, 1 daily, QTY: 30, 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-steroidal anti-inflammatory drugs) Page(s): Page: 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of proton pump inhibitors (PPIs) such as omeprazole (also known as Prilosec). These guidelines state that the use of a PPI is determined by whether the patient has gastrointestinal (GI) symptoms and whether they are at risk for a significant GI event. The guidelines state the following: NSAIDs, GI symptoms & cardiovascular risk: Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. Recommendations 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 (200 g 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. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardio protection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is Naproxyn plus low-dose aspirin plus a PPI. In this case there is no documentation provided in the available records that the patient has a history of a significant gastrointestinal problem such as a history of a peptic ulcer, GI bleeding or perforation. Further, the patient is less than 65 years of age. The patient does not appear to be currently taking an aspirin, a corticosteroid or is on an anticoagulant. Therefore, the patient appears to be at low risk for a gastrointestinal event. Under these conditions, the use of a PPI such as omeprazole (Prilosec) is not medically necessary.

NSAIDs, GI symptoms & cardiovascular risk: Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. Recommendations 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 (200 g 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. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. In this case there is no documentation provided in the available records that the patient has a history of a significant gastrointestinal problem such as a history of a peptic ulcer, GI bleeding or perforation. Further, the patient in under 65 years of

age. The patient does not appear to be currently taking an aspirin, a corticosteroid or is on an anticoagulant. Therefore, the patient appears to be at low risk for a gastrointestinal event. Under these conditions, the use of a PPI such as omeprazole (Prilosec) is not considered as a medically necessary treatment.