

Case Number:	CM14-0095144		
Date Assigned:	07/25/2014	Date of Injury:	06/04/2009
Decision Date:	02/25/2015	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/23/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Physical Medicine & Rehabn

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 patient is a 57 year old male with an injury date of 06/04/09. Based on the 04/25/14 progress report provided by treating physician, the patient complains of low back pain radiating to right leg rated at 7/10. Physical examination dated 02/24/14 to the cervical spine revealed tenderness to palpation diffusely at the base of the neck. Physical examination to the lumbar spine revealed tenderness to palpation in the paraspinal musculature. Range of motion was decreased, especially on extension. There is a positive straight leg raise bilaterally. Patient has had a CSI injection in the CMC joint on 09/04/12. Patient has had 8 visits of acupuncture and 6 visits of PT. Patient's current medication include Norco, LidoPro and Omeprazole. MRI of the lumbar spine on 10/20/11 showed: 1) DDD with facet arthropathy and retrolistheses L2-3, L4-5, and L5-S1. 2) Canal stenosis includes L4-5 mild canal stenosis. 3) Neural foraminal narrowing L2-3 mild caudal right and L4-5 mild left neural foraminal narrowing. Patient is currently permanent and stationary. Diagnosis (02/24/14)- Right lumbar radiculopathy- Lumbar facet arthropathy- Bilateral knee DJD. The utilization review determination being challenged is dated 05/21/14. The rationale follows: "There is no clear evidence presented of significant risk for gastrointestinal events or of significant gastrointestinal symptoms necessitating use of this medication."Treatment reports were provided from 02/24/14 to 04/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and Cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 69.

Decision rationale: The patient presents with low back pain radiating to right leg rated at 7/10. The request is for Omeprazole 20mg Qty 60. There is a positive straight leg raise bilaterally. Patient has had a caudal steroid injection (CSI) in the carpometacarpal (CMC) joint on 09/04/12. Patient has had 8 visits of acupuncture and 6 visits of physical therapy (PT). Patient's current medications include Norco, LidoPro and Omeprazole. MRI of the lumbar spine on 10/20/11 showed: 1) degenerative disc disease (DDD) with facet arthropathy and retrolistheses L2-3, L4-5, and L5-S1. 2) Canal stenosis includes L4-5 mild canal stenosis. 3) Neural foraminal narrowing L2-3 mild caudal right and L4-5 mild left neural foraminal narrowing. Patient is currently permanent and stationary. Regarding non-steroidal anti-inflammatory drugs (NSAIDs) and gastrointestinal/cardiovascular (GI/CV) risk factors, MTUS requires determination of risk for GI events including age > 65; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID. MTUS page 69 states "NSAIDs, GI symptoms and cardiovascular risk: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI [proton pump inhibitor]." Per progress report dated 04/25/14, treater states "Prilosec 1 tablet per day for gastirc complaints and [the patient] uses LidoPro ointment for neuropathic pain." However, treater has not documented GI assessment to warrant a prophylactic use of a PPI. The patient is not even on any oral NSAIDs. Furthermore, it has been more than 3 months from the UR date of 05/21/14, and treater has not indicated how the patient is doing, what gastric complaints there are, and why he needs to continue. Therefore, given lack of documentation as required my guidelines, the request is not medically necessary.