

<b>Case Number:</b>	CM15-0101845		
<b>Date Assigned:</b>	06/04/2015	<b>Date of Injury:</b>	03/14/2013
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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 & Rehabilitation, Pain Management

### 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 sustained an industrial injury on March 14, 2013. She has reported low back pain and right shoulder pain and has been diagnosed with right shoulder partial cuff tear, status post right shoulder arthroscopy, and chronic lumbar strain with disc herniation. Treatment has included medication and physical therapy. Examination of the lumbar spine noted tenderness in the midline and tenderness in the paraspinals. There was limited range of motion due to pain. Asymmetric loss of range of motion. Examination of the right shoulder showed palpation over the acromioclavicular joint and greater tuberosity of the shoulder was painless. There was no tenderness in the subacromial space or bicipital groove. Forward flexion and abduction is 160 degrees, internal and external rotation to 70 degrees. There was a positive Hawkins and Neer's test. The treatment request included Omeprazole 20 mg # 30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole 20mg quantity 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines proton pump inhibitors (PPI) Page(s): 68-69.

**Decision rationale:** Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no medication list to confirm NSAID use, or that the patient has complaints of dyspepsia, a risk for gastrointestinal events, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.