

<b>Case Number:</b>	CM15-0137064		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	06/18/2004
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	06/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2015

### 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: Massachusetts

Certification(s)/Specialty: Anesthesiology, 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 is a 67 year old (DOB 08/16/1948) female who sustained an industrial injury on 06/18/2004. Treatment provided to date has included: previous lumbar fusion surgery (no date mentioned), medications, and conservative therapies/care. Diagnostic tests performed include: x- rays of the lumbar spine (2015) showing status post fusion of T11-S1 with a metallic rod from previous surgery that is approximately 2cm below the surface of the skin. There were no noted comorbidities or other dates of injury noted. Several documents within the submitted medical records are difficult to decipher; however, on 05/20/2015, physician progress report noted complaints of back pain. No pain rating or description was mentioned. Recent medications include gabapentin, Percocet, tizanidine, and Duragesic patches. The physical exam revealed decreased range of motion in the low back and tenderness in the lumbar spine. The provider noted diagnoses of lumbar spine disc disorder. Plan of care includes neurosurgical consultation. The injured worker's work status noted as retired. The request for authorization and IMR (independent medical review) includes: omeprazole 20mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole 20mg quantity 90:** Overturned

**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 PPI Page(s): 68-69.

**Decision rationale:** The MTUS makes the following recommendations for the use of proton pump inhibitors. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the injured worker 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 Injured workers with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) Injured workers 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 ug 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). Injured workers at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Injured workers 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. Cardiovascular disease: A non-pharmacological choice should be the first option in injured workers with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short-term needs. An opioid also remains a short-term alternative for analgesia. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is naproxyn plus low-dose aspirin plus a PPI. Mild to moderate risk factors: If long-term or high-dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If naproxyn is ineffective, the suggested treatment is (1) the addition of aspirin to naproxyn plus a PPI, or (2) a low-dose Cox-2 plus ASA. According to the records available for review, the injured worker is intermediate risk per MTUS above and consequently a PPI is medically necessary. Therefore, at this time, the requirements for treatment have been met and medical necessity has been established.