

<b>Case Number:</b>	CM15-0181817		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	03/19/2001
<b>Decision Date:</b>	11/30/2015	<b>UR Denial Date:</b>	08/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 52 year old male who sustained an industrial injury on 03/19/2001. Medical records indicated the worker was treated for pain in both knees and lower back. In the provider notes of 07-21-2015, the injured worker complains of neck pain with radiation to the scapular right greater than left area with intermittent tingling and numbness in the upper extremities, headaches, dizziness, memory dysfunction, scar sensitivity over the right vertex with a triggering of headaches as well as a numb spot on the right vertex along the scar. He has secondary depression and insomnia related to his complaints. On exam, the worker continues to have slight to moderately antalgic gait due to bilateral knee pain. The worker uses a walking cane. His paracervical muscles show slight to moderate spasm, right greater than left, in upper and mid region. Inspection shows loss of lordosis. Spurling's sign is negative on lateral flexion. With neck extension the worker has a reproduction of right cervical radicular symptoms with pain and numbness into the right hand. Diagnoses on that date include post traumatic head syndrome with post traumatic headaches, post traumatic vertigo, and memory dysfunction. He has cervical strain with right sided radiculitis. He has scalp area scar sensitivity with neuralgic pain on the right vertex from his original head injury. He has secondary depression due to chronic pain. He has stomach upset thought to be due to Nonsteroidal anti-inflammatory drugs/opioids used for pain. The treatment plan included authorization of his current medications of Norco, Naproxen, Zoloft, Ambien, and Omeprazole. A request for authorization was submitted for 1. Naproxen Sodium 550mg #602, Zoloft 50mg #303, Pamelor 25mg4, Omeprazole 20mg #60A utilization review decision non-certified all of the requests.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Naproxen Sodium 550mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications.

**Decision rationale:** The patient was injured on 03/19/01 and presents with neck pain, headaches, dizziness, memory dysfunction, depression, insomnia, and sear sensitivity over the right vertex. The request is for Naproxen Sodium 550MG #60 for pain. The RFA is dated 08/17/15 and the patient is permanent and stationary. The patient has been taking this medication as early as 01/07/15. MTUS Guidelines, Anti-inflammatory Medications section, page 22 states, "Anti- inflammatories are the traditional first line of treatment to reduce pain, so activity and functional restoration can resume, but long-term use may not be warranted." The patient has slight to moderately antalgic gait because of bilateral knee pain, uses a walking cane, has moderate spasm of the cervical spine, loss of lordosis, and neck extension causes pain in the right upper extremity. He is diagnosed with post traumatic head syndrome with post traumatic headaches, post traumatic vertigo, memory dysfunction, cervical strain with right sided radiculitis, scalp area scar sensitivity with neuralgic pain on the right vertex from his original head injury, secondary depression due to chronic pain, and stomach upset. The treater does not specifically discuss efficacy of Naproxen on any of the reports provided. MTUS Guidelines page 60 states that when medications are used for chronic pain, recording of pain and function needs to be provided. Due to lack of documentation, the requested Naproxen is not medically necessary.

### **Omeprazole 20mg #60: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** The patient was injured on 03/19/01 and presents with neck pain, headaches, dizziness, memory dysfunction, depression, insomnia, and sear sensitivity over the right vertex. The request is for Omeprazole 20 MG #60 for stomach upset due to pain medication and to prevent gastritis from NSAIDs/opioids. The utilization review rationale is that documentation provides no evaluation of the patient's symptoms or effectiveness of this medication. The RFA is dated 08/17/15 and the patient is permanent and stationary. The patient has been taking this medication as early as 01/07/15. MTUS guidelines, NSAIDs, GI symptoms & cardiovascular risk section, page 68 states that omeprazole is recommended with precaution for patients at risk for gastrointestinal events: 1. Age greater than 65. 2. History of peptic ulcer disease and GI bleeding or perforation. 3. Concurrent use of ASA or corticosteroid and/or

anticoagulant. 4. High dose/multiple NSAID. MTUS continues to state, "NSAIDs, GI symptoms, and cardiovascular risks: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2 receptor antagonist or a PPI." The patient has slight to moderately antalgic gait because of bilateral knee pain, uses a walking cane, has moderate spasm of the cervical spine, loss of lordosis, and neck extension causes pain in the right upper extremity. He is diagnosed with post traumatic head syndrome with post traumatic headaches, post traumatic vertigo, memory dysfunction, cervical strain with right sided radiculitis, scalp area scar sensitivity with neuralgic pain on the right vertex from his original head injury, secondary depression due to chronic pain, and stomach upset. As of 07/21/15, the patient is taking Norco, Naproxen, Zoloft, Pamelor, and Ambien. Given that the patient continues to have stomach upset, the requested Omeprazole appears reasonable. Use of PPIs is indicated for GI issues, as this patient presents with. Therefore, the requested Omeprazole is medically necessary.