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| <b>Case Number:</b>   | CM15-0187567 |                              |            |
| <b>Date Assigned:</b> | 09/29/2015   | <b>Date of Injury:</b>       | 03/20/2013 |
| <b>Decision Date:</b> | 11/09/2015   | <b>UR Denial Date:</b>       | 08/27/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/23/2015 |

### 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: 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 is a 51 year old male who sustained an industrial injury on 03/20/2013. Medical records indicated the worker was treated for headaches, cervical, thoracic and lumbar radiculopathy, right shoulder tendinitis, right ulnar nerve, right carpal tunnel syndrome, a right knee sprain, bilateral plantar fasciitis, and tarsal tunnel syndrome. In the provider notes of 06-03-2015, the injured worker complains of headaches, neck pain, bilateral shoulder pain, upper and mid back pain, low back pain, bilateral knee pain, bilateral ankle and foot, and bilateral hand and wrist pain. On exam, his headache was over the occipital, constant in frequency and moderate intensity with exacerbations to moderate to severe triggered by overhead looking, and range of motion. The neck likewise had pain that was constant infrequency, moderate intensity noted over the bilateral paracervical with radiation to the bilateral shoulders. Exacerbation occurred with range of motion. The upper extremities had pain over the bilateral shoulders that was constant and moderate, and associated with limited range of motion. Range of motion exacerbated the pain to a moderate severe intensity. The upper extremity pain was noted over the bilateral elbow and associated with range of motion. The pain was described as sharp and numb in character. In the bilateral wrists and hands the pain was constant in frequency, moderate intensity, and associated with range of motion. The chest-ribs-upper back pain was bilateral and constant in frequency with moderate intensity described as sharp in character. The pain was exacerbated to a level of moderate to severe by prolonged sitting, driving, occasional bending, pushing and pulling. In the medical history part of the exam, he denied current or previous illness. The abdomen was soft and non-tender with no organomegaly, masses or bruits.

Normal bowel sounds were present and he had no hepatosplenomegaly or hernias. The neck had tenderness and spasms over the paracervical and trapezial region bilaterally. Range of motion was diminished in all planes. Range of motion was diminished in all planes in the bilateral shoulders, and there was tenderness and spasm noted over the bilateral trapezius and AC joint. Impingement tests were positive. The elbow and forearm exams showed no restriction in range of motion. Valgus and Varus signs were negative as was a test for medial epicondylitis, and lateral epicondylitis. There was tenderness noted over the palmar aspect of the bilateral wrists. Range of motion was normal. The upper back had tenderness and spasms over the bilateral paravertebral regions. The lower back had tenderness and spasms over the bilateral paravertebral regions. Tests of the bilateral knees were negative for patellofemoral pathology or meniscal tears or chondromalacia patella. In the feet, tests for potential Tarsal Tunnel syndrome were positive. The treatment plan included prescriptions of Norflex, Anaprox, and Prilosec. Recommendations were made for further testing. The work status was restricted. There was no documentation of gastrointestinal issues, concurrent use of aspirin, corticosteroids and-or an anticoagulant. A request for authorization was submitted for Prilosec (unspecified strength and quantity). A utilization review decision 08-27-2015 denied the request for Prilosec.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Prilosec (unspecified strength and quantity): 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): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** The claimant sustained a work injury in March 2013 and is being treated for injuries sustained while performing demolition. He had low back pain which spread and now has pain affecting multiple body areas. When seen, he was taking naproxen as needed. He has a negative past medical history. Physical examination findings included a body mass index over 34. There was tenderness and spasm throughout the spine. There was decreased shoulder range of motion. Diagnoses included cervical, thoracic, and lumbar radiculopathy, right carpal tunnel syndrome, bilateral plantar fasciitis and tarsal tunnel syndrome, a right knee sprain, right ulnar nerve injury, headaches, and anxiety. Anaprox, Prilosec, and Norflex were prescribed. Guidelines recommend an assessment of gastrointestinal symptoms and cardiovascular risk when NSAIDs are used. In this case, the claimant does not have any identified risk factors for a gastrointestinal event. The claimant is under age 65 and has no history of a peptic ulcer, bleeding, or perforation. There is no documented history of dyspepsia secondary to the naproxen that the claimant was already taking. The prescribing of a proton pump inhibitor such as Prilosec (omeprazole) is not medically necessary.