

Case Number:	CM15-0028696		
Date Assigned:	02/20/2015	Date of Injury:	06/17/2003
Decision Date:	04/10/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	02/17/2015

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: District of Columbia, Virginia
Certification(s)/Specialty: Internal Medicine

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 55 year old male, who sustained an industrial injury on June 17, 2003. He has reported an injury to his right shoulder after he fell off a roof. The diagnoses have included lumbar/lumbosacral disc degeneration, sprain lumbar region and lumbosacral neuritis. Treatment to date has included diagnostic studies, epidural steroid injection, stretching exercises and medications. On February 9, 2015, the injured worker complained of increased low back and lower extremity pain, right greater than left. The pain travels to the buttocks, posterior thigh and calves down to dorsum of the feet. He has associated numbness and tingling. His symptoms were noted to have returned to baseline. The epidural steroid injection provided 85% improvement for 6 weeks followed by 50% improvement up until six weeks prior to exam date. On January 20, 2015, Utilization Review non-certified Ranitidine 150mg #30, noting the Official Disability Guidelines. On February 17, 2015, the injured worker submitted an application for Independent Medical Review for review of Ranitidine 150mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ranitidine tab 150mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Integrated Treatment/Disability Duration Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 68. Decision based on Non-MTUS Citation ODG-proton pump inhibitors.

Decision rationale: MTUS and ACOEM do not specifically address ranitidine, an H2 blocker. They do address PPIs. Per MTUS: NSAIDs, GI symptoms & cardiovascular risk. Recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient 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: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.), Patients 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 g 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). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Per ODG: MTUS does not address this medication. Per ODG: proton pump inhibitors (PPI) are recommended for patients at risk for gastrointestinal events. See NSAIDs, GI symptoms and cardiovascular risk. Prilosec (omeprazole), Prevacid (lansoprazole) and nexium (esomeprazole) are PPIs. Omeprazole provides a statistically significantly greater acid control than lansoprazole (Miner 2010). Healing doses of PPIs are more effective than all other therapies although there is an increase in overall adverse effects to placebo. Nexium and Prilosec are very similar molecules. For many people, Prilosec is more affordable than nexium. Nexium is not available in a generic (as in Prilosec). Also, prilosec is more available as an over the counter product while nexium is not. (Donnellan 2010) In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose or the shortest possible amount of time. PPIs are more effective including preventing gastric ulcers induced by NSAIDs. Studies suggest however that nearly half of all PPI prescriptions are used for unapproved indications or no indications at all. Many prescribers believe that this class of drugs is innocuous but much information is available to demonstrate otherwise. If a PPI is used, omeprazole OTC tablets or lansoprazole 24 HR OTC are recommended for an equivalent clinical efficacy and significant cost savings. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including nexium, prevacid, prilosec, protonix, dexilant and aciphex (Shi 2008). A trial of omeprazole or lansoprazole is recommended before nexium therapy. The other PPIs, protonix, dexilant, aciphex should also be second line. According to the latest AHRQ comparative effectiveness research, all of the commercially available PPIs appeared to be similarly effective (AHRQ 2011) (Pain Chapter). This patient was found to have issues with GERD (gastro-esophageal reflux disease). The symptoms were exacerbated when the patient was on an NSAID, indomethacin, which was used to treat pain issues. Per guidelines, this patient had issues with GERD and should be on a PPI, such as omeprazole. Ranitidine would not be indicated.