

Case Number:	CM15-0084536		
Date Assigned:	05/06/2015	Date of Injury:	02/23/2012
Decision Date:	06/09/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/02/2015

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: Ohio, North Carolina, Virginia
 Certification(s)/Specialty: Family Practice

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 44 year old female, who sustained an industrial injury on 2/23/12. She has reported initial complaints of chest pain, shortness of breath, right hip and right knee pain after striking her knee on the console. The diagnoses have included orotracheal gastritis and other specified gastritis. Treatment to date has included medications, bracing, acupuncture, diagnostics, physical therapy and home exercise program (HEP). Currently, as per the physician progress note dated 4/8/15, the injured worker complains of acute upper gastrointestinal pain under the diaphragm on the left side. She stopped Omeprazole and Nizatidine. She is off her medications and there is no nausea. The physical exam revealed abdomen soft, non-tender, no masses with normal bowel sounds. The current medications included Flexeril, Ultram, Xolido cream, Cyclobenzaprine/Tramadol compounded cream, Nizatidine and Omeprazole. The progress noted dated 2/4/15 noted that she is better on Omeprazole and Nizatidine and if she misses one she gets bloated. The physician noted that he was not sure what this pain is from that it might be diverticular disease and that he will stop all her medications. She will be followed often with H2 blockers and she will continue with dietary restrictions. It was also noted that she is to stay off the Nonsteroidal anti-inflammatory drugs. There was no previous urine drug testing noted in the records. Work status was to return to full duty. The physician requested treatments included Omeprazole 20mg quantity 160 and Urinalysis Drug Screening.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg quantity 160: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Establishing the Diagnosis of Gastroesophageal Reflux Disease, Katz PO, Gerson LB, Vel MF.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk Page(s): 69.

Decision rationale: For the treatment of dyspepsia secondary to NSAID therapy the CA MTUS recommendations are to stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. In this instance, the injured worker has a clinical diagnosis of gastritis and GERD thought in part to be from NSAIDS and in part from job related stress. The NSAIDS were discontinued but the epigastric pain and burning continued. She was also said to have vomited flecks of blood and have bloody stools. An upper GI endoscopy was discussed in the notes but not evidently completed. Her initial symptoms did not respond to H2 antagonist therapy alone and so Omeprazole 20 mg twice a day was added. Her symptoms were said to be decidedly better on Omeprazole than Nizatidine on 2-4-2015. The guidelines state that proton pump inhibitor therapy such as Omeprazole is an option for dyspepsia secondary to NSAID therapy. It is clear that the NSAIDS were discontinued and the GI symptoms have improved but continue to some degree. The guidelines do not specify a length of proton pump inhibitor therapy for dyspepsia from NSAIDS and hence it would seem more a matter of clinical judgment when to discontinue treatment. The guidelines do not seem to imply that proton pump inhibitor therapy must be stopped simultaneously when NSAIDS are also discontinued. Therefore, Omeprazole 20 mg #160 is medically necessary and appropriate.

Urinalysis Drug Screening: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Urine Drug Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Pain (Chronic) chapter. Urine drug testing section.

Decision rationale: Those prescribed opioids chronically require ongoing assessment of pain relief, functionality, medication side effects, and any aberrant drug taking behavior. Monitoring for aberrant drug taking behavior should take the form of urine drug screening, pill counts, and pharmacy database inquiries. In this instance, the utilization reviewer did not certify a recently requested urine drug screen on the basis that the prescribed opioid, Tramadol, was not certified. Therefore, there should be no need for urine drug screening. Tramadol, however, continued to be prescribed by the treating physician. Per the Official Disability Guidelines: Urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of

undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. This information includes clinical observation, results of addiction screening, pill counts, and prescription drug monitoring reports. The prescribing clinician should also pay close attention to information provided by family members, other providers and pharmacy personnel. It seems, from the guidelines, that opioid therapy does not necessarily have to be utilized in the present sense to justify urine drug testing. The clinician may utilize this tool when considering a treatment adjustment or to identify undisclosed substances. Therefore, urine drug screening is medically appropriate and necessary in this instance.