

Case Number:	CM14-0120312		
Date Assigned:	08/08/2014	Date of Injury:	09/14/2005
Decision Date:	10/15/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	07/30/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 41-year old woman has chronic neck, back and upper extremity pain since an injury on 9/14/05. Treatment to date has included medications, physical therapy, cervical fusion and L shoulder rotator cuff surgery. There is only one progress note from the primary treater in the available records, dated 6/23/14. No review of systems is included. Medications are listed as Norco 10/325 four to five times a day, Prilosec two times a day, Reglan, fenofibrate 145 mg one time daily, furosemide 40 mg and "rarely metachlorpramide" 10 mg as needed. She also takes Elavil, Zantac and Baclofen prescribed by her primary care physician. She complains of nausea, constipation and gas which she thinks may be due to taking Norco and Baclofen. No other GI complaints are documented. A history of treatments to date includes "ibuprofen with minimal temporary relief", "Advil with minimal relief" and BC powder with caffeine. The rest of the documented history and physical exam are related to the patient's neck and back pain. Diagnoses include degenerative disc disease of the cervical and lumbar spine with radiculopathy, lumbar facet syndrome, and cervical adjacent segment disease. Requests were listed for Norco 10/325 #150, omeprazole 20 mg #60, for cervical interlaminar epidural steroid injections, for triple phase bone scan, for a lumbar medical branch block, for a general orthopedic follow-up, and for a pain management consult. The request for omeprazole was denied in UR on 7/23/14, and a request for IMR was generated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole DR Capsules 20mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors (PPIs) Page(s): 102.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 6. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, an evidence-based online review service for clinicians, (www.uptodate.com) , Omeprazole: drug information

Decision rationale: The first guideline cited above states that clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. They should determine if the patient is at risk for GI events. Risk factors include age over 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of aspirin, corticosteroids, or an anticoagulant; or high-dose or multiple NSAIDs, or an NSAID combined with aspirin. Patients with no GI risk factors and no cardiovascular disease may be prescribed a non-selective NSAID. Those at intermediate risk for GI disease should receive a non-selective NSAID plus a proton pump inhibitor (PPI) or misoprostol; or a Cox-2 selective NSAID. Patients at high GI risk should receive a Cox-2 selective NSAID and a PPI if an NSAID is absolutely necessary. This reference notes that long-term PPI use has been shown to increase the risk of hip fracture. The UptoDate reference cited above lists the indications for omeprazole as active duodenal ulcer, gastric ulcer, erosive esophagitis, helicobacter pylori eradication, pathological hypersecretory conditions (such as Zollinger-Ellison syndrome), frequent heartburn, GERD or other acid-related disorders, NSAID-induced ulcer treatment, NSAID-induced ulcer prophylaxis, and stress ulcer prophylaxis in ICU patients. The last three indications are off label. Risks of long-term (usually over one year) use include atrophic gastritis, increased incidence of gastric carcinoid tumors, clostridium difficile-associated diarrhea, increased incidence of osteoporosis-related fractures of the hip, spine, or wrist; hypomagnesemia and Vitamin B12 deficiency. The usual dosing for Omeprazole is 20 mg once daily. Prilosec is brand-name omeprazole, which is a proton pump inhibitor. It is impossible to guess from the available clinical records why omeprazole is being prescribed for this patient. There is no documentation of her risk for GI events. It is not clear whether or not she is taking an NSAID. Ibuprofen and Advil (which is brand-name ibuprofen) are listed as ineffective historical treatments. BC powder, which contains aspirin and caffeine, is also listed as a historical treatment. It is not clear whether or not the patient is still taking aspirin, which is an NSAID. There is no documentation of any condition likely to require a PPI prescription or of any symptoms suggestive of such a condition. Nausea and constipation are not indications for omeprazole. The patient is taking three medications for gastrointestinal problems including Reglan (metoclopramide), and Zantac. It appears possible that she has been taking Prilosec for at least a year, which would put her at risk for the side effects listed above, many of which could be life threatening, particularly since she is taking it at twice the usual dose. Based on the evidence-based references cited above and the available clinical information, Omeprazole DR 20 mg #60 is not medically necessary because there is no documentation of any benefit to the patient that is likely to outweigh its risks.