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| Case Number: | CM14-0146432 | | |
| Date Assigned: | 09/12/2014 | Date of Injury: | 09/12/2012 |
| Decision Date: | 10/14/2014 | UR Denial Date: | 08/01/2014 |
| Priority: | Standard | Application Received: | 09/09/2014 |

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 machine operator reported neck and low back pain after being struck on the head by a roll of bubble wrap weighing about 20 lbs. on 9/12/12. The available records are incomplete. They document that the patient received bilateral medial branch blocks and acupuncture, and that epidural steroid injections have been requested but non-certified. Medications have included long-term Diclofenac and tramadol. It is not clear what other treatments (including medications) the patient has received. A request for Diclofenac and Tramadol, and for omeprazole 20 mg #30 which had been dispensed on 5/28/14 was retroactively certified in UR. Per the primary provider's most recent progress noted dated 7/2/14, current diagnoses include chronic low back pain, chronic neck pain, status post head injury and headaches. The patient continues to have constant moderate to severe neck and back pain. The exam is essentially normal except for some tenderness and spasm of the low back musculature. Ranges of motion are normal and no radicular signs are documented. Past medical history and review of systems are documented as "unchanged". There is no documentation of any gastrointestinal complaints. The patient's work status is documented as "P&S". Meds dispensed include Diclofenac XR 100 mg, omeprazole 20 mg # 30, and Tramadol ER 150 mg. The stated rationale for the omeprazole is "reduce NSAID gastritis prophylaxis". A request for authorization dated 7/24/14 included omeprazole 20 mg #30, which was non-certified in UR on 8/1/14. An appeal letter dated 9/4/14 from the primary physician cites the MTUS guidelines regarding NSAID use and GI risk stratification, but does not state what risk category the patient fits into. A request for IMR of the 8/1/14 was determined not medically necessary of omeprazole and was also generated on 9/4/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole DR 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines gastrointestinal (GI) Prophylaxis Page(s): 22, 68, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69. 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 Up-to-date 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 treating physician in this case has stated that he is dispensing omeprazole for prophylaxis of NSAID gastritis. The available records do not contain any documentation that the patient has any history of ulcers, GI bleeding or perforation. There are no documented gastrointestinal complaints in any of the records. There is no documentation of concurrent aspirin, corticosteroid or anticoagulant use. He does not take high-dose or multiple NSAIDs. He appears to be at low risk for GI events, and therefore should be able to take a non-selective NSAID such as Diclofenac without the addition of a PPI such as omeprazole. There is no documentation of any of the other diagnoses for which omeprazole is commonly prescribed, as listed in the second reference. The evidence-based references cited above and the clinical findings in this case do not support the use of omeprazole. Omeprazole is not medically necessary because the available documentation places the patient at low risk for GI events, because he does not have another condition that would require the use of omeprazole, and because omeprazole has significant possible side effects, some of which may be life threatening. This request is not medically necessary.