

Case Number:	CM14-0098006		
Date Assigned:	07/28/2014	Date of Injury:	11/30/2004
Decision Date:	11/12/2015	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	06/26/2014

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. 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: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, 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:

This is a 60-year-old male with a date of industrial injury 11-30-2004. The medical records indicated the injured worker (IW) was treated for Status post L4-5 and L5-S1 interbody fusion (1995) and L1-2 through L3-4 (2006) and medication-induced gastritis. In the progress notes (5-13-14), the IW reported 75% relief of his lower back pain and radicular symptoms since the epidural steroid injection he received on 5-1-14. He complained of increasing right knee pain. Medications included MS Contin, Norco, Valium, Zoloft, Cialis, testosterone injections, FexMid, Prilosec and Oxycontin. The IW (5-13-14 notes) walked with a single point cane. Cervical and lumbar paraspinal muscles were tender, with trigger points noted. Lumbar ranges of motion were decreased from normal according to the notes and lower extremity muscle testing was decreased in the L3 through S1 myotomes bilaterally. Treatments included right knee steroid injections and trigger point injections, which provided temporary relief. There were no documented complaints of dyspepsia or gastritis. A Request for Authorization was received for Prilosec 20mg, #60. The Utilization Review on 6-10-14 non-certified the request for Prilosec 20mg, #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Capsules of Prilosec 20mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 1. Goodman and Gilman's, The Pharmacological Basis of Therapeutics, 12th ed, McGraw Hill, 2006. 2. Physician's Desk Reference, 68th ed. 3. WWW.RxList.com. 3. ODG Workers Compensation Drug Formulary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (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). CPMTG guidelines further specify: "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 mg 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 necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxen plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, medical necessity is not necessary.