

<b>Case Number:</b>	CM15-0018441		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	10/15/2002
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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: Massachusetts

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 41-year-old male sustained an industrial injury on 10/15/02, with subsequent ongoing low back pain. In a visit note dated 12/11/14, the injured worker complained of pain 9/10 on the visual analog scale. The injured worker reported that the pain interfered with his relationships and his ability to sleep. Work status was permanent medical disability. Physical exam was remarkable for tenderness to palpation in the sciatic notch on the right with trigger points palpated in the lower trapezius, gluteus and quadratus lumborum bilaterally, limited lumbar spine range of motion, paresthesias to light touch in the medial and lateral left leg and medial right leg. Current diagnoses included lumbosacral strain, lumbar disc degeneration and myofascial pain. The treatment plan included a psychiatric consultation, continuing medications (Biscodyl, Diazepam, Doc-q-lace, Famotidine, Hydromorphone, Senna, Morphine Sulfate, Gralise, Protonix, Naproxen Sodium and Omeprazole) and discontinuing Biofreeze with Ilex Gel, Cymbalta and Cyclobenzaprine. On 1/7/14, Utilization Review noncertified a request for Omeprazole Cap 20mg noting no significant gastrointestinal symptoms and citing CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole Cap 20mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPI  
Page(s): 68-69.

**Decision rationale:** The MTUS makes the following recommendations for the use of proton pump inhibitors. 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. 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 naproxyn plus low-dose aspirin plus a PPI. Cardiovascular disease: A non-pharmacological choice should be the first option in patients with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short term needs. An opioid also remains a short-term alternative for analgesia. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is naproxyn plus low-dose aspirin plus a PPI. Mild to moderate risk factors: If long-term or high-dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If naproxyn is ineffective, the suggested treatment is (1) the addition of aspirin to naproxyn plus a PPI, or (2) a low-dose Cox-2 plus ASA. According to the records available for review the patient does not meet any of the guidelines required for the use of this medication therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.