MAXIMUS Federal Services

Case Number:	CM15-0120228		
Date Assigned:	06/30/2015	Date of Injury:	01/22/2007
Decision Date:	09/01/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	06/22/2015

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: New York
Certification(s)/Specialty: Pediatrics, Internal Medicine

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 49 year old male, who sustained an industrial injury on 01/22/2007. He reported that while parking a forklift, the right rear tire came off, and slammed the forklift into the ground. He subsequently complained of sudden severe pain in his neck. MRI revealed spinal cord abnormalities and he underwent cervical spine surgery. Treatment to date has included medications, surgeries, epidural injections, physical therapy, electrodiagnostic studies, and spinal cord stimulator placement. Diagnoses included status post anterior cervical discectomy and fusion C4-5 and C5-6, status post disc replacements at C3-4 and C6-7, subsequent spinal cord stimulator implantation; resultant cephalgia, status post 3 left shoulder surgeries including arthroscopic labral and subacromial debridement with rotator cuff repair; possible recurrent rotator cuff tear, status post right ulnar nerve transposition with medical epicondylar debridement with current cubital tunnel syndrome, bilateral carpal tunnel syndrome, psychiatric diagnoses, internal medicine diagnoses and sleep disturbance. According to a progress report dated 04/30/2015, the injured worker returned for a follow up. He had been seen by a spine specialist and there was nothing further that could be done surgically for this cervical spine at that point. The provider noted that he still did not have the report yet. The injured worker felt that his left shoulder pain was significant enough to consider surgery. He had already had 3 prior left shoulder surgeries. He was no longer a candidate for an MRI due to his spinal cord stimulator. He was very familiar with the appropriate exercises for the shoulder. He had problems with his hands and wrists that were evident on electrodiatnostic studies. He continued to have problems sleeping due to pain and mental stress. The provider noted that on the last visit, he had requested

that the injured worker get a new pain management specialist. He was very uncomfortable prescribing a large amount of narcotics required by this injured worker. The provider noted that he still had not received that authorization and that it did not appear as though there was a very large list of pain management specialist that would provide medicine dispensing responsibilities in that area. The injured worker remained permanent and stationary. He was on a home exercise program. The provider noted that he would see how soon the injured worker could get in to see a pain medicine specialist. The injured worker requested a refill of his Soma, Hydrocodone, Omeprazole and Imitrex that was given to him by his neurologist. The injured worker understood that the provider could not prescribe MS Contin. He had enough of the Celebrex and Cymbalta that had been given to him by his private physician. He was taking approximately 8 Hydro-codone tablets a day. Due to the injured worker's weakness and prior rotator cuff repair and failure to respond to ongoing home exercise, the provider wanted a CT arthrogram of the left shoulder to be done. The injured worker continued to treat with his private physician regarding his psychiatric and internal medicine complaints. The provider requested authorization for Soma, Omeprazole, Imitrex and Norco. Currently under review is the request for Omeprazole 20mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (Non-Steroidal Anti-Inflammatory Drugs) GI (Gastrointestinal) Symptoms & Cardiovascular Risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines list risks for gastrointestinal events and includes age > 65 years, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of aspirin, corticosteroids and and/or an anticoagulant or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Official Disability Guidelines (ODG) states that proton pump inhibitors are recommended for patients at risk for gastrointestinal events. Decision to use proton pump inhibitors long-term must be weighed against the risks. The potential adverse effects of long-term proton pump inhibitor use included B12 deficiency, iron deficiency, hypomagnesemia, increased susceptibility to pneumonia, enteric infection and fractures, hypergastrinemia and cancer and more recently adverse cardiovascular effects. Proton pump inhibitors have a negative effect on vascular function, increasing the risk for myocardial infarction. Patients with gastroesophageal reflux disease on proton pump inhibitors had a 1.16 greater risk of myocardial infarction and a 2.00 risk for cardiovascular mortality. Proton pump usage may be serving as a marker for a sicker population, but this is unlikely, given the lack of increased risk seen in patients taking H2 blockers. (Shah, 2015) In this study proton pump inhibitor use was associated with a 1.58 fold greater risk of myocardial infarction and in the case-crossover study, adjusted odds ratios of proton pump

inhibitor for myocardial risk were 4.61 for the 7 day window and 3.47 for the 14 day window. However, the benefits of proton pump inhibitors may greatly outweigh the risks of adverse cardiovascular effects, with number needed to harm of 4357. (Shih, 2014) Outpatient proton pump use is associated with a 1.5 fold increased risk of community-acquired pneumonia, with the highest risk within the first 30 days after initiation of therapy. (Lamber, 2015) The updated Beers Criteria, which help prevent adverse drug events in older adults, added a recommendation to avoid the use of proton pump inhibitors for more than 8 weeks, except for long-term NSAID users and patients with erosive esophagitis, Barrett's esophagitis, pathologic hypersecretory condition, or a demonstrated need for maintenance therapy. There are many studies demonstrating, in elderly patients, an increased risk for Clostridium difficile infection and bones loss and fractures with the long-term use of proton pump inhibitors. (AGS, 2015) In this case, there was no discussion that the injured worker was at risk for a gastrointestinal event. There were no gastrointestinal complaints noted by the injured worker in recent documentation. Long-term use of proton pump inhibitors are not recommended. As such, the request for Omeprazole 20mg #60 is not medically necessary.