

<b>Case Number:</b>	CM15-0078986		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	04/10/2005
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	04/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2015

### 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: Florida, New York, Pennsylvania  
 Certification(s)/Specialty: Family Practice

### 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 57 year old female, who sustained an industrial injury on 4/10/2005. She reported a slip and fall with injury to the back, left knee and hand. Diagnoses include acute posttraumatic cervical sprain and left shoulder sprain, chronic lumbar disc bulge and radiculopathy, left greater trochanteric bursitis, and depression secondary to chronic pain. She is status post left knee surgery x 2 and left carpal tunnel release. Treatments to date include lumbar facet rhizotomy, cortisone injections, psychotherapy, and medication therapy. Currently, she complained of neck and low back pain with radiation to the left upper extremity associated with numbness, tingling, and weakness. On 3/20/15, the physical examination documented tenderness in the cervical and lumbar muscles, over the wrist joint, as well as the left knee. The plan of care included continuation of medication therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prevacid SA 30mg, #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter - Proton pump inhibitors (PPIs).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.uptodate.com](http://www.uptodate.com) Drugs that affect bone density, Rosen HR, review current through April 2015.

**Decision rationale:** The ACOEM MTUS does not directly address the issue of PPIs and medication induced gastritis. This complex pain syndrome patient has been maintained on Fentanyl, Dilaudid and Cymbalta. A report from 14 Oct 14 indicated that there was a pre-existing problem with reflux and dyspepsia that had been aggravated by NSAID use and ongoing pain medications were also reported to have continued to exacerbate the problem. It was noted that Prevacid had been beneficial in decreasing symptoms. A psychiatric summary evaluation 10 Nov 14 in discussing the use of Cymbalta indicated it was causing heartburn. A decrease from bid to qd for Prevacid had also resulted in increased heartburn. An issue was raised in regard to the use of PPIs and an increased risk of hip fracture as a reason to discontinue the use of the PPI. The most recent information on this issue from the largest available cohort study did not find an association between PPI use and hip fracture (HR 1.00, 95% CI 0.71-1.40). As a reminder it was stated that while observational studies may find associations they will not prove causality and must be treated with caution. Another cohort study looking at 10 years of PPI use was not associated with accelerated decline in BMD. Lastly the suggestion was made that the provider managing the patients diabetes should also manage the need and use for PPIs. It was unclear if this provider was a general internist or diabetologist who may not be comfortable managing gastrointestinal issues. Also the pain management provider appeared to be reviewing the patients status on a monthly basis and also managing the spectrum of medications associated with the complaints of reflux and heartburn. Taken as a whole the patient appears to have had an ongoing issue with reflux and heartburn, exacerbated by pain management medications who has responded to PPI use and whose symptoms worsened as the dose was reduced. The risk for hip fracture with long term use of PPIs has not been supported on the basis of large cohort studies which trump observational studies. Therefore the benefit of continued use of PPIs for this patient are supported as is the continued supervision by the treating pain management provider. Therefore, the request is medically necessary.