

<b>Case Number:</b>	CM15-0079779		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	03/24/2011
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	03/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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: North Carolina  
 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 male, who sustained an industrial injury on March 24, 2011. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having cervical strain with disc herniations and degenerative disc disease, radiculitis, left shoulder impingement syndrome, left shoulder rotator cuff tendinitis, low back pain with degenerative disc disease, knee internal derangement, and gastritis from non-steroidal anti-inflammatory drug prophylaxis. Diagnostics to date has included MRI and x-rays. Treatment to date has included acupuncture, physical therapy, a home exercise program, shoe orthotics, and medications including anti-epilepsy, opioid, and proton pump inhibitor. On February 27, 2015, the injured worker complains of improved left shoulder pain, continued ankle pain, and lower back pain. The orthotics he obtained from the podiatrist is providing him with pain relief. His medications help his pain. Prolonged walking worsens his symptoms. His pain low back level is rated 8/10. The physical exam revealed decreased cervical range of motion and normal bilateral upper extremities reflexes. The lumbar spine exam revealed an antalgic gait, tenderness and muscle spasming of the paralumbar musculature, normal motor testing and reflexes of the bilateral lower extremities, decreased lumbar range of motion, and decreased sensation of the right sacral 1 nerve root distribution. The left shoulder exam revealed tenderness of the greater tuberosity and acromioclavicular joint, decreased strength with resisted abduction, and decreased range of motion. The left knee exam revealed well-healed scars, limited motion, crepitus, pain on full flexion, and patellofemoral facet tenderness. The treatment plan includes continuing the Omeprazole and Voltaren XR.

## 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, GI symptoms, and cardiovascular risk Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68-70.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID therapy and proton pump inhibitors (PPI) states: Recommend with precautions as indicated below. 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 gastro duodenal 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 (200g 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 gastro-intestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. There is no documentation provided that places this patient at intermediate or high risk that would justify the use of a PPI. There is no mention of current gastrointestinal or cardiovascular disease. For these reasons the criteria set forth above per the California MTUS for the use of this medication has not been met. Therefore the request is not medically necessary.

**Diclofenac XR 100mg #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Diclofenac Socium Page(s): 71.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68-72.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all

NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs- Cochrane, 2008) See also Anti-inflammatory medications. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. This medication is recommended for the shortest period of time and at the lowest dose possible. The dosing of this medication is within the California MTUS guideline recommendations. The definition of shortest period possible is not clearly defined in the California MTUS. Therefore the request is certified.