

Case Number:	CM14-0141302		
Date Assigned:	09/10/2014	Date of Injury:	06/12/2013
Decision Date:	10/06/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/02/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 37-year old dental assistant has a date of injury of 6/12/13. The available records do not include a description of the mechanism of injury. Current diagnoses include chronic neck pain, R shoulder impingement, R elbow contusion, R wrist strain, chronic low back pain, R knee contusion, depression, anxiety and difficulty sleeping. Her primary treater is an orthopedist who has been following her since July 2013. Treatment has included medications (documented as including Naprosyn, Tramadol, Vicodin and Prilosec), physical therapy, and steroid injections to her R knee and R wrist. MRIs of the lumbar spine and R knee were requested and denied in UR, possibly on the basis that these body parts were not part of the original injury (records not available). There are progress notes from the primary treater in the available records from 2/20/14 to 5/1/14, which document pain in the patient's neck, R shoulder, R elbow, R wrist and R knee which has not improved. At each of these visits, Naprosyn 550 mg twice per day #60 and Prilosec 20 mg # 60 were prescribed, with 4 refills of both medications at every visit. There is no documentation of a rationale for the prescription of Prilosec in any of these visits. There is a report of a comprehensive final orthopedic evaluation on 4/3/14 which specifically states that the patient has no GI complaints including nausea, diarrhea, constipation, flatus, changes in bowel habits, indigestion or other gastrointestinal problems; the other notes simply state that the patient's review of systems is unchanged. The patient has not worked since the date of injury and remains at total disability status. The available records do not contain the 8/12/14 request for authorization for omeprazole or the undated unsigned Medical Necessity Justification referred to in the 8/19/14 UR report. According to the UR report, the request for authorization was for omeprazole without a stated dose or quantity, and the Medical Necessity Justification document states: Prilosec (omeprazole) at bedtime to protect his/her stomach from the effects of the medications (on Anaprox-Nsaid and Medrol topical). There was no applicable progress note

available for review by the UR physician, and there is none in the records currently available. The request for Prilosec was denied in UR on 8/19/14. A request for IMR regarding the decision was generated on 8/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole (unspecified quantity & Dosage): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation UptoDate, an evidence-based online review service for clinicians, (www.uptodate.com) , Omeprazole: drug information

Decision rationale: The first guideline cited above states that clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. They should determine if the patient is at risk for GI events. Risk factors include age over 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of aspirin, corticosteroids, or an anticoagulant; or high-dose or multiple NSAIDs, or an NSAID combined with aspirin. Patients with no GI risk factors and no cardiovascular disease may be prescribed a non-selective NSAID. Those at intermediate risk for GI disease should receive a non-selective NSAID plus a proton pump inhibitor (PPI) or misoprostol; or a Cox-2 selective NSAID. Patients at high GI risk should receive a Cox-2 selective NSAID and a PPI if an NSAID is absolutely necessary. This reference notes that long-term PPI use has been shown to increase the risk of hip fracture. The UptoDate reference cited above lists the indications for omeprazole as active duodenal ulcer, gastric ulcer, erosive esophagitis, helicobacter pylori eradication, pathological hypersecretory conditions (such as Zollinger-Ellison syndrome), frequent heartburn, GERD or other acid-related disorders, NSAID-induced ulcer treatment, NSAID-induced ulcer prophylaxis, and stress ulcer prophylaxis in ICU patients. The last three indications are off label. Risks of long-term (usually over one year) use include atrophic gastritis, increased incidence of gastric carcinoid tumors, clostridium difficile-associated diarrhea, increased incidence of osteoporosis-related fractures of the hip, spine, or wrist; hypomagnesemia and Vitamin B12 deficiency. Prilosec is brand-name omeprazole, which is a proton pump inhibitor. The first clinical issue in this case is that the request for this medication does not include a dosage or number for the omeprazole prescription. An authorization of this request could therefore mean that the patient would be authorized continue to take omeprazole at the dosage documented in the progress notes, (twice per day, which is twice the usual dosage) or higher, for life. The documented reason for prescribing omeprazole in this case is to protect the patient's stomach from the effects of Naproxen and topical Medrol. The documentation available in the records would place this patient at low risk for GI events. This would mean that naproxen should be prescribed without the addition of protective agent such as omeprazole. There is no documentation of any condition likely to require a PPI prescription, or of any symptoms suggestive of such a condition. It appears likely that the patient has been taking Prilosec for up to a year at twice the usual dose which would put

her at high risk for the side effects listed above, many of which could be life threatening. Based on the evidence-based references cited above and the available clinical information, omeprazole is not medically indicated in this case. It is not medically necessary because it is not indicated for patients at low risk for GI events, because the quantity is not specified which would make any authorization completely open-ended, and because there is no documentation of any possible benefit to the patient that is likely to outweigh its risk.