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| Case Number: | CM14-0149896 | | |
| Date Assigned: | 09/18/2014 | Date of Injury: | 07/02/2009 |
| Decision Date: | 10/20/2014 | UR Denial Date: | 08/15/2014 |
| Priority: | Standard | Application Received: | 09/15/2014 |

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 Physical Medicine and Rehabilitation 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:

The injured worker is a 68-year-old male who sustained an injury on 7/2/09. On 2/6/14, he indicated changes in his digestion, diarrhea and constipation. On 5/19/14, he complained of lower-level pain radiating into both legs, which was progressively getting worse. He has depression. He stated that medications helped to decrease his pain intensity. Exam showed decreased lumbar ROM (range of motion), positive SLR (straight leg raise) bilaterally, spasm and tenderness of the lumbar paraspinal muscles, decreased knee ROM bilaterally, positive crepitus, and tenderness to the medial and lateral joint line. MRI of the lumbar spine dated 9/24/09 revealed broad-based posterior disc protrusion at L2-3, L3-4, and L4-5 and questionable broad-based posterior disc protrusion at L5-S1. MRI of the left knee dated 3/10/11 indicated mild-to-moderate DJD (degenerative joint disease). He underwent a left knee arthroscopic surgery in 2001, 2002, 2009, and 2010; and carpal tunnel surgery in 1987 and 1999. Current medications include Anaprox, Zanaflex, tramadol, Valium and Prilosec. Report from 2010 indicated gastrointestinal disorders, constipation, cramping and discomfort, and acid reflux. Report of 9/27/13 indicated that he had stomach pain and constipation. Diagnoses include chronic pain syndrome secondary to HLD (herniated lumbar disc); herniated lumbar disc with radiculitis; status post left knee arthroscopy; right knee internal derangement; anxiety and depression; and insomnia. According to reports of 2010, 2013, and 2014 Prilosec was prescribed and refilled multiple times with last reported refill on 05/19/14. The request for Prilosec 20 mg #30 was denied on 08/15/14 in accordance with medical guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-69.

Decision rationale: The CA MTUS guidelines state PPI medications such as Omeprazole (Prilosec) may be indicated for patients at risk for gastrointestinal events, which should be determined by the clinician: 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). The guidelines recommend GI protection for patients with specific risk factors, however, the medical records do not establish the patient is at significant risk for GI events; Treatment of dyspepsia secondary to NSAID therapy recommendation is to stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. Furthermore, Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture In this case, there is no evidence of significant dyspepsia unresponsive to change of NSAID and the above criteria are not met. Thus, the medical necessity of Prilosec has not been established in accordance with the CA MTUS guidelines.