

<b>Case Number:</b>	CM13-0071913		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	08/06/2012
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	12/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2013

### 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 Anesthesiologist Pain Medicine and is licensed to practice in Florida. 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 23-year-old male who reported an injury on 08/16/2012. The mechanism of injury was not stated. Current diagnoses include status post lumbar decompressive surgery at L5-S1 in 01/2013, status post microlumbar decompressive surgery in 01/2012, and lumbar radiculopathy. The injured worker was evaluated on 12/04/2013. The injured worker reported 7/10 lower back pain with radiation to the left lower extremity. The injured worker has completed 15 sessions of chiropractic therapy. Current medications include Norco, Prilosec, and Terocin cream. Physical examination revealed limited lumbar range of motion, intact sensation and 4/5 strength in the left EHL. Treatment recommendations at that time included additional chiropractic therapy and a prescription for Lidopro topical ointment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **8 CHIROPRACTIC TREATMENTS FOR THE LUMBAR SPINE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

**Decision rationale:** Chronic Pain Medical Guidelines state manual therapy and manipulation are recommended if caused by a musculoskeletal condition. Treatment for the low back is recommended with a therapeutic trial of 6 visits over 2 weeks. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. The injured worker has completed 15 sessions of chiropractic therapy to date. An additional 8 sessions of chiropractic therapy would exceed guideline recommendations. There is also no documentation of objective functional improvement following the initial course of treatment. Despite ongoing treatment, the injured worker continues to report 7/10 pain. Based on the clinical information received, the request is not medically necessary.

**PRESCRIPTION OF OMEPRAZOLE 20MG, #60:** 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 Page(s): 68-69.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective (NSAID) non-steroidal anti-inflammatory drug. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the injured worker does not meet criteria for the use of a proton pump inhibitor. There is also no frequency listed in the current request. As such, the request is not medically necessary.

**1 PRESCRIPTION OF LIDO PRO TOPICAL OINTMENT 4 OZ:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56,111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no evidence of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the current request. Therefore, the request is not medically necessary.