

<b>Case Number:</b>	CM14-0076616		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	01/24/2009
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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 Nevada. 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 records presented for review indicate that this 48 year-old individual was reportedly injured on January 24, 2009. The mechanism of injury is noted as a blunt force trauma, being struck by a door in her back. The most recent progress note, dated July 1, 2014, indicates that there are ongoing complaints of persistent back and shoulder pain. The physical examination demonstrated a loss of range of motion, normal blood pressure (123/86) and tenderness to palpation in the posterior cervical spine musculature. Diagnostic imaging studies were not reviewed. Previous treatment includes multiple medications and conservative care. A request had been made for multiple medications and chiropractic care and was not certified in the pre-authorization process on May 20, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Topamax 50mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs), Topiramate (Topamax) Page(s): 16-21.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs), Topiramate (Topamax) Page(s): 17.

**Decision rationale:** The use of antiepileptic or anticonvulsant medications can be supported in the face of certain clinical situations. There has to be objective occasion that first-line anti-convulsants have been tried and have failed. There is limited clinical information presented for review and there is no data presented to suggest the need for antiepileptic medications. There is objectification of a neuropathic lesion that is the pain generator. As such, there is insufficient clinical data to support the medical necessity of this medication. Therefore, the request of Topamax 50mg #60 is not medically necessary and appropriate.

**Six (6) Chiropractic manipulation sessions for right shoulder and neck: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

**Decision rationale:** This type of intervention is recommended by musculoskeletal conditions. However, this is not supported in the long-term phrase particularly with no particular physical examination findings to support this. Furthermore, a brief trial of this intervention is endorsed by the MTUS prior to a long-term intervention. As such, based on the clinical information presented for review there is insufficient clinical data to support this request. Therefore, the request of six (6) Chiropractic manipulation sessions for right shoulder and neck is not medically necessary and appropriate.

**Amrix 15mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Cyclobenzaprine (Flexeril) Page(s): 63-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41, 64.

**Decision rationale:** This is a muscle relaxant type medication. As outlined in the MTUS, this is only indicated for short-term interventions for acute flares of symptomology. This is not clinically indicated for chronic or indefinite use. The progress notes indicate chronic neck pain and muscle spasms as such; there is no efficacy or utility established with the use of this medication. Therefore, the request of Amrix 15mg #60 is not medically necessary and appropriate.

**Xanax 1mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** This medication is a Benzodiazepine used for the treatment of anxiety disorders and panic disorders. There were no complaints of either, while noting there is an element of depression outlined in the diagnosis listed; there were no clinical findings to support this diagnosis. Furthermore, this medication is not recommended for long-term use because the long-term efficacy is unproven. Therefore, when noting the parameters outlined in the MTUS tempered by the clinical assessment provided, the request of Amrix 15mg #60 is not medically necessary and appropriate.

**Protonix 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms Page(s): 67-69, 73. Decision based on Non-MTUS Citation ODG, Proton Pump Inhibitors (PPIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68.

**Decision rationale:** This type of medication is useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for those utilizing non-steroidal medications. Given that there are no non-steroidal medications prescribed, tempered by the fact that there are no complaints of gastric upset, and taking the consideration the parameters outlined in the MTUS the medical necessity for this medication is not objectified in the progress of presented for review. As such, the request of Protonix 20mg #60 is not medically necessary and appropriate.