

<b>Case Number:</b>	CM14-0078474		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	09/02/2012
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	05/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2014

### 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 & Rehabilitation and is licensed to practice in Illinois. 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 31-year-old male who reported an injury on 09/02/2012. The mechanism of injury was not stated. Current diagnoses include low back pain, lumbosacral or thoracic neuritis or radiculitis, lumbar facet syndrome, left-sided lumbar radiculopathy, and myofascial pain. The injured worker was evaluated on 05/05/2014. The injured worker reported ongoing lower back pain with radiation into the lower extremities. Previous conservative treatment includes medication management and acupuncture. Physical examination revealed limited lumbar range of motion, 5/5 motor strength, intact sensation, tenderness to palpation in the left lower facet joints, and positive straight leg raising. Treatment recommendations included a refill of the current medication regimen, continuation of acupuncture, and continuation of a home exercise program with TENS therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole 20 mg #60 by mouth twice per day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** The California MTUS Guidelines states that "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." There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the request is not medically necessary.

**Diclofenac Sodium ER 100 mg #30 one by mouth 4 times per day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Formulary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** The California MTUS Guidelines states that "NSAIDS are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDS are recommended as a second line option after acetaminophen." As per the documentation submitted, the injured worker has utilized this medication since 02/2014. There is no documentation of objective functional improvement. The California MTUS Guidelines do not recommend long term use of NSAIDS. As such, the request is not medically necessary.

**TENS patch:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** the California MTUS Guidelines states that "transcutaneous electrotherapy is not recommended as a primary treatment modality, but a one month home-based trial may be considered as a noninvasive conservative option." As per the documentation submitted, there is no evidence of a failure to respond to other appropriate pain modalities. There is also no documentation of a successful one month trial with evidence of how often the unit was used and outcomes in terms of pain relief and function. Therefore, the request cannot be determined as medically appropriate. As such, the request is not medically necessary.

**Lidopro ointment 121 gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The California MTUS Guidelines states that "topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." There is no documentation 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. As such, the request is not medically necessary.