

<b>Case Number:</b>	CM14-0095975		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	12/18/2013
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2014

### 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 Internal 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:

The injured worker is a 35 year old female who sustained an injury on 12/18/13 when she was involved in a motor vehicle accident. The injured worker was rear ended when she sustained injuries to the neck and low back. The injured worker was initially provided chiropractic treatment which provided no relief of symptoms. No imaging for the cervical spine was performed. The injured worker was seen on 06/02/14 for complaints of both neck and low back pain. The injured worker was noted to be utilizing Prozac at this evaluation. The injured worker's physical examination noted tenderness in the trapezii bilaterally. There was some limited range of motion in the cervical spine. No neurological deficits were identified. There was also muscle spasms noted in the right paralumbar musculature with tenderness over the L4 to L5 spinous processes. Again, no neurological deficits were identified. There was some loss of lumbar range of motion. Radiographs noted some loss of the normal cervical lordosis. The requested six sessions of chiropractic therapy, Naproxen 550 milligrams, Protonix 20 milligrams, Mentherm topical cream, and Tramadol extended release (ER) 150 milligrams were all denied by utilization review on 06/06/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **6 Sessions of Chiropractic Therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Therapeutic Care Page(s): 58.

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

**Decision rationale:** The most recent clinical report did not specify a rationale for continuing chiropractic therapy. It is documented that the injured worker previously obtained chiropractic treatment without benefit. Given the lack of response to previous chiropractic treatment, it is unclear what further benefits would be obtained with continuing chiropractic treatment. Therefore, this request is not medically appropriate.

**Naproxen 550mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

**Decision rationale:** The most recent evaluation for this injured worker did not identify any specific rationale for this prescribed medication. Given the injured worker's injury and evidence of musculoskeletal complaints, it is unclear what benefits would be obtained with the use of this medication at this point in time over the standard over the counter medications. Furthermore, the request is not specific in regards to frequency, quantity, or duration. Therefore, this request is not medically necessary.

**Protonix 20mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPI Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Pain Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) Pain Chapter, proton pump inhibitors.

**Decision rationale:** In review of the clinical documentation submitted, there is insufficient documentation to support the use of this medication. The most recent evaluation for this injured worker did not identify any specific rationale for this prescribed medication. Given the injured worker's injury and evidence of musculoskeletal complaints, it is unclear what benefits would be obtained with the use of this medication at this point in time over the standard over the counter medications. Furthermore, the request is not specific in regards to frequency, quantity, or duration. Therefore, this request is not medically necessary.

**Menthoderm Topical Cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 105.

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

**Decision rationale:** In review of the clinical documentation submitted, there is insufficient documentation to support the use of this medication. The most recent evaluation for this injured worker did not identify any specific rationale for this prescribed medication. Given the injured worker's injury and evidence of musculoskeletal complaints, it is unclear what benefits would be obtained with the use of this medication at this point in time over the standard over the counter medications. Therefore, this request is not medically necessary.

**Tramadol ER 150mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): , 88-89.

**Decision rationale:** In review of the clinical documentation submitted, there is insufficient documentation to support the use of this medication. The most recent evaluation for this injured worker did not identify any specific rationale for this prescribed medication. Given the injured worker's injury and evidence of musculoskeletal complaints, it is unclear what benefits would be obtained with the use of this medication at this point in time over the standard over the counter medications. Furthermore, the request is not specific in regards to frequency, quantity, or duration. Therefore, this request is not medically necessary.