

<b>Case Number:</b>	CM14-0143245		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	09/02/2012
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2014

### 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 31 year-old male was reportedly injured on 9/2/2012. The mechanism of injury is noted as a low back injury while reaching forward to mix dough with right the arm. The most recent progress note dated 9/8/2014, indicates that there are ongoing complaints of low back pain with radiation to the left lower extremity. Physical examination demonstrated lumbar spine flexion/extension about 50-60%; strength 5/5; sensation was intact; "SLR he complains of tightness in the back"; minimal tenderness over the left lower facet joints. Electrodiagnostic studies dated 12/19/2012 showed evidence of a left L5 radiculopathy. MRI of the lumbar spine dated 1/14/2013 documented grade I degenerative spondylosis, disk bulge/protrusion without canal stenosis or nerve impingement at L5-S1; disk bulge, facet arthropathy and moderate bilateral foraminal stenosis at L4-L5. Diagnosis: low back pain, lumbosacral or thoracic neuritis/radiculitis, lumbar face syndrome, myofascial pain, knee pain and gastritis. Previous treatment includes physical therapy, TENS, HEP and medications to include Diclofenac ER, Topiramate, Lidopro ointment and Omeprazole. A request had been made for Omeprazole 20mg #60, date of service (DOS) 8/04/14, Topiramate 50mg #60, date of service (DOS) 8/04/14, TENS patch x 2 pairs, date of service (DOS) 8/04/14, which were determined not medically necessary in the utilization review on 8/18/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Omeprazole 20mg #60, date of service (DOS) 8/04/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69 of 127.

**Decision rationale:** MTUS treatment guidelines support the use of proton pump inhibitors (PPI) in patients taking non-steroidal anti-inflammatory medications with documented gastroesophageal distress symptoms and/or significant risk factors. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fractures. Review of the available medical records, documents a diagnosis of gastritis, but fails to document any signs or symptoms of GI distress which would require PPI treatment. Given the lack of clinical documentation, this request is not considered medically necessary.

**Topiramate 50mg #60, date of service (DOS) 8/04/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 21.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 21 OF 127.

**Decision rationale:** MTUS guidelines support the use of anti-convulsants, but notes that Topiramate (Topamax) may be used as a 2nd line agent after other anti-convulsants have been trialed and failed. Review of the available medical records, fails to document a 1st line agent trial or failure to a trial. Given the lack of clinical documentation, this request is not considered medically necessary.

**TENS patch x 2 pairs, date of service (DOS) 8/04/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) P.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113 - 116 of 127..

**Decision rationale:** MTUS treatment guidelines recommends against using a TENS unit as a primary treatment modality and indicates that a one-month trial must be documented prior to purchase of the unit. Based on the clinical documentation provided, the TENS unit is being used as a primary treatment modality. Review of the available medical records fails to document objective clinical findings of neuropathic pain, phantom limb pain, CRPS, MS or a spinal cord injury which are the criteria per MTUS guidelines. The guideline criteria has not been met for a TENS unit; therefore, TENS unit supplies and patches are not considered medically necessary.