

<b>Case Number:</b>	CM14-0146791		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	11/27/2013
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	09/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2014

### 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 Family Practice, and is licensed to practice in Texas and Mississippi. 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 62-year-old male who reported an injury on 11/27/2013, due to an unknown mechanism. Diagnoses were cervical disc protrusion, right shoulder impingement, lumbar disc protrusion, right shoulder full thickness tear of biceps tendon, right elbow tendinosis and bilateral wrists sprain/strain. Physical examination on 09/04/2014 revealed complaints of sharp, stabbing pain in the bilateral shoulders, bilateral arms, bilateral elbows, lumbar spine and bilateral hands and wrists. The pain was rated 4/10 to 5/10. Examination revealed tenderness of the lumbar spine, decreased range of motion, muscle spasms and positive Kemp's test. Examination of the cervical spine revealed tenderness to palpation, decreased range of motion and positive muscle spasm. Examination of the shoulders revealed tenderness to palpation, decreased range of motion, right greater than the left. Examination of the elbows revealed tenderness to bilateral elbows and bilateral wrists. The treatment plan was for chiropractic therapy for 12 sessions and medications as directed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic therapy for 12 sessions:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

**Decision rationale:** The decision for chiropractic therapy for 12 sessions is not medically necessary. The California Medical Treatment Utilization Schedule states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement at total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle and foot, carpal tunnel syndrome, the forearm, wrist and hand or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks and at 8 weeks patients should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. The clinical information submitted for review does not provided evidence to justify chiropractic therapy for 12 sessions. There was a lack of documentation of objective findings. Therefore, this is request is not medically necessary.

**Omeprazole 20mg, #60:** Upheld

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

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

**Decision rationale:** The decision for Omeprazole 20mg, #60 is not medically necessary. Clinicians should determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, Ibuprofen, Naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or misoprostol (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. The efficacy for this medication was not reported. The request did not indicate a frequency for the medication. There were no other significant factors provided to justify the continued use of this medication. Therefore, this request is not medically necessary.