

<b>Case Number:</b>	CM13-0001255		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	12/27/2002
<b>Decision Date:</b>	02/14/2014	<b>UR Denial Date:</b>	07/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/12/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, 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 physician 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 patient is a 64 year old female who reported an injury on 12/27/2002. The patient was diagnosed with lumbar levoscoliosis, lumbar disc protrusions, lumbar radiculitis, lumbar facet joint pain, sacroiliac joint pain, and left 1st metacarpal phalangeal joint arthritis. The patient has undergone bilateral knee replacement in 2007, revision of bilateral matrixectomy of her great toes in 2007, left knee arthroscopy and left foot neuroma removal in 1990, cesarean section in 1981, laparoscopy in 1979, and bilateral matrixectomy of her great toes in 1978. According to the treatment physician's pain management consultation report from 10/10/2013, the patient actually had date of injury listed as 08/12/2002, 11/2001, and 1990 to 12/27/2002. She has been seen for chronic moderate lumbosacral pain, chronic pain status post bilateral total knee replacement, left thumb pain, and cervicothoracic tension. The patient has had continued back pain which is over the inferior aspect of the scapula with associated dysesthesias. She rates her pain at 3/10. She states medication helps keep her pain relatively low and allows her to remain partially functional. She has also used aquatic therapy, but has declined injection therapy in favor of relatively low cost medication management, occasional manual therapy, and exercise. Under the physical examination, it was noted the patient has no decrease in cervical range of motion and is negative for all cervical orthopedic tests to include cervical compression, cervical distraction, shoulder depression, Bakody's sign. Examination of the thoracic spine noted T7 through T8 right paravertebral back pain which is over the inferior aspect of the scapula worse than the right side with associated dysesthesias, but no motor weakness detected.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment Thoracic spine x6 visits: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** The MTUS Chronic Pain Guidelines state that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. The goal is to achieve positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Therapeutic care is listed as a trial of 6 visits over 2 weeks, and with evidence objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. In the case of this patient, her injury is more than 10 years old and it was noted the patient had been utilizing aquatic therapy in most recent documentations. The MTUS Chronic Pain Guidelines state extended durations of care beyond what is considered maximum may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. However, as the documentation does not state the patient has undergone previous chiropractic treatments, a trial of 6 visits for the thoracic spine would be considered appropriate in this case. As such, the request for 6 chiropractic treatments for the thoracic spine is medically necessary and appropriate.

**Hydrocodone 5/500mg #120 no refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** The MTUS Chronic Pain Guidelines state that to continue opioids, a patient must have returned to work or have shown improved functioning, as well as a decrease in pain. Furthermore, it notes that the criteria to discontinue opioids includes when a patient has no overall improvement in function, unless there are extenuating circumstances, continuing pain with evidence of intolerable adverse effects, decrease in functioning, resolution of pain, if serious non-adherence is occurring, and the patient is requesting discontinuance. In the case of this patient, there is little to no evidence of objective functional improvement or pain reduction with the use of her hydrocodone. Therefore, at this time, it is unclear if the medication is medically necessary for continuation of care. Without having sufficient documentation providing objective measurements pertaining to the functional improvement and reduction in pain, the medical necessity for hydrocodone cannot be established. As such, the request for Hydrocodone 5/500 mg # 120 is not medically necessary and appropriate.

**Diazepam 5mg # 60 no refills: Upheld**

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

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

**Decision rationale:** The MTUS Chronic Pain Guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. In the case of this patient, it is unclear how long the patient has been utilizing diazepam. There are no objective measurements pertaining to the efficacy from the use of this medication. Therefore, the medical necessity to continue the use of diazepam 5 mg cannot be established. Due to both the non-recommendation for long-term use of benzodiazepines, as well as the lack of objective information pertaining to the efficacy of this medication, the requested service cannot be warranted at this time. As such, the request for Diazepam 5mg # 60 is not medically necessary and appropriate