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| Case Number: | CM13-0037397 | | |
| Date Assigned: | 12/13/2013 | Date of Injury: | 12/09/2006 |
| Decision Date: | 02/03/2014 | UR Denial Date: | 09/27/2013 |
| Priority: | Standard | Application Received: | 09/30/2013 |

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 Family Practice 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 49 year old female who reported an injury on 12/09/2006. The patient is currently diagnosed with lumbalgia, neuralgia, neuritis, radiculitis, and rotator cuff syndrome. The patient was seen by [REDACTED] on 10/12/2013. The patient reported 10/10 pain with weakness, numbness, and tingling. Physical examination revealed diminished cervical and lumbar spine range of motion, diminished left shoulder range of motion, and decreased sensation at C5-T2. Treatment recommendations included continuation of current medications, an orthopedic consultation, TENS unit, and chiropractic manipulative therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

. Chiropractic treatment as needed: Upheld

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

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

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. As per the

clinical notes submitted, the patient has previously participated in chiropractic treatment. Documentation of the previous course of therapy with treatment duration and efficacy was not provided for review. Additionally, there is no intended duration and frequency of treatment noted in the request. Based on the clinical information received, the request is non-certified.

Soma 350 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations in patients with chronic low back pain. However, they show no benefit beyond NSAIDs in pain and overall improvement. Carisoprodol is not recommended for longer than 2 to 3 weeks. As per the clinical notes submitted, the patient has continuously utilized this medication. The patient does not demonstrate palpable muscle spasm or muscle tension on physical examination that would warrant the need for a muscle relaxant. There is no indication of a failure to respond to first-line therapy prior to the initiation of a second-line muscle relaxant. The satisfactory response to treatment has not been indicated. As such, the request is non-certified.