

Case Number:	CM14-0106483		
Date Assigned:	07/30/2014	Date of Injury:	04/02/2009
Decision Date:	09/10/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/09/2014

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 Physical Medicine & Rehabilitation, and is licensed to practice in Texas & Oklahoma. 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 36-year-old male who was injured after being assaulted by an inmate on 04/02/2009. The clinical note dated 06/11/2014 indicated a diagnosis of left sided radiculopathy. The injured worker reported pain to his low back. The injured worker reported numbness and tingling down through his lower extremities with a burning sensation to his legs. The injured worker reported his left leg locked up on him. The injured worker reported he had difficulty with movement and reported his back locked up on him. The injured worker reported decompression therapy and massage therapy helped greatly relieve pain and maintained mobility. On physical examination of the lumbar spine, the injured worker was unable to forward flex passed his knees without tightness and pain. Rotation of the trunk to the left and right elicited pain and pulling to the left side. The injured worker's straight leg raise test was positive on the left side with gross sensation diminished throughout the left side. The injured worker's treatment plan included request of electromyogram/nerve conduction study to the lower extremities, request of Toradol injection, and Norco refill, request decompression therapy to alleviate the pain and numbness down the low back, and continue permanent restrictions. Medication instructions and warnings were discussed with the injured worker. The injured worker's prior treatments included diagnostic imaging, decompression therapy, and medication management. The injured worker's medication regiment included Norco. The provider submitted a request for decompression management. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Decompression Therapy sessions qty 6.00: Upheld

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.

Decision rationale: The request for Decompression Therapy sessions quantity 6.00 is not medically necessary. The CA MTUS guidelines recommend manual therapy for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. There is lack of documentation indicating the injured worker has significant objective functional improvement with the prior therapy. In addition, there is lack of documentation regarding a complete physical exam to evaluate for decreased functional ability, decreased range of motion, and decreased strength and flexibility. Moreover, the amount of decompression therapy the injured worker previously completed was not provided in the documentation submitted to warrant additional therapy. In addition, the submitted request does not specify the site for treatment. Therefore, the request for Decompression Therapy sessions quantity 6.00 is not medically necessary.

Norco 10/325mg qty 360: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for Norco 10/325mg quantity 360 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risk for aberrant drug use, behaviors, and side effects. In addition, it was not indicated how long the injured worker had been utilizing this medication. Moreover, the request does not indicate a frequency. Additionally, it was not indicated if the injured worker had a signed opioid contract. Therefore the request for Norco 10/325mg quantity 360 not medically necessary.