MAXIMUS Federal Services

Case Number:	CM14-0032169		
Date Assigned:	06/20/2014	Date of Injury:	04/02/2009
Decision Date:	10/09/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/13/2014

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 Illinois. 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 reported an injury on 04/02/2009. The mechanism of injury was not provided. On 06/11/2014, the injured worker's diagnoses were lumbar L4-5 disc bulge status post surgery, contusion of the bilateral knees, right hand sprain, right knee sprain and left side radiculopathy. Upon examination of the lumbar spine, the injured worker was unable to forward flex past his knees without tightness and pain. Rotation of the trunk to the left and right elicits pain and pulling to the left side. There was a positive left sided straight leg raise and diminished sensation to the left side. The provider recommended chiropractic care, massage therapy, and Norco tablets; the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Care/Massage Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59, 60.

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

Decision rationale: The request for Chiropractic Care/Massage Therapy is not medically necessary. The California MTUS state that chiropractic care for chronic pain if caused by musculoskeletal conditions is recommended. The intended goal or effect of manual medicine is the 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. The guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of functional improvement, a total of up to 18 visits over 6 to 8 weeks. There is lack of documentation indicating the injured worker had significant objective functional improvement with the prior therapy. The amount of chiropractic treatments the injured worker underwent was not provided. Additionally, the provider's request does not indicate the amount of chiropractic care/massage therapy visits being requested, the frequency of the visits, or the site at which the therapy was indicated for in the request as submitted. As such, medical necessity has not been established.

Norco Tablets 10/325 MG Quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88-89, 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The request for Norco Tablets 10/325 MG Quantity 60 is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse, behaviors, and side effects. The efficacy of the prior use of the medication was not provided. The provider's request does not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.