

<b>Case Number:</b>	CM14-0079740		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	08/19/2002
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	04/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/30/2014

### 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 Internal Medicine 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 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 injured on 08/19/02 when involved in a motor vehicle collision. Diagnoses include neck pain, cervical degenerative disc disease, right shoulder pain, chronic headaches, and low back pain. Clinical note dated 07/22/14 indicated the injured worker presented complaining of neck pain, headaches, right shoulder pain, and right-sided low back pain. The injured worker rated pain at 8/10 without medications and 2/10 with the use of pain medications. Physical examination revealed positive straight leg raise on the right, restricted cervical spine range of motion, limited active range of motion in the right shoulder, 5/5 strength of bilateral upper and lower extremities, 2+ deep tendon reflexes for both biceps, and triceps and normal gait. Medications include Fioricet, Xanax, Ultram, and Gabapentin. The initial request for Fioricet #60, acupuncture 6 visits, and chiropractic visits 2-3 per month times 12 months was initially non-certified on 05/30/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fioricet #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

**Decision rationale:** As noted on page 23 of the Chronic Pain Medical Treatment Guidelines, use of Fioricet, a barbiturate-containing analgesic, is not recommended for treatment of chronic pain. Research indicates the potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy. Additionally, there is no indication in the documentation that establishes the benefits associated with the use of the medication. As such, the continued use of Fioricet #60 is not medically necessary and appropriate.

**Acupuncture 6 visits:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** As noted in the Acupuncture Medical Treatment Guidelines, the frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed 1 to 3 times per week with an optimum duration over 1 to 2 months. Guidelines indicate that the expected time to produce functional improvement is 3 to 6 treatments. Acupuncture treatments may be extended if functional improvement is documented. Current guidelines recommend an initial trial period of 3 - 4 sessions over 2 weeks with evidence of objective functional improvement prior to approval of additional visits. As such, the request for Acupuncture 6 visits cannot be recommended as medically necessary.

**Chiropractic visits per year two to three per month x 12 months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 59.

**Decision rationale:** Current guidelines indicate chiropractic frequency of 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks with a maximum duration of 8 weeks. At week 8, patients should be reevaluated. 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. In these cases, treatment may be continued at one treatment every other week until the injured worker has reached plateau and maintenance treatments have been determined. 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. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. As such, the request for chiropractic visits per year two to three per month x 12 months is not medically necessary and appropriate.