

<b>Case Number:</b>	CM14-0081288		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	05/18/2001
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	05/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 Occupational 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:

According to the records made available for review, this is a 47-year-old male with a 5/18/01 date of injury. At the time (3/26/14) of request for authorization for range of motion and muscle strength testing, Carisoprodol 350MG, QTY 60, and chiropractic treatment with physiotherapy and myofascial release, QTY 6. There is documentation of subjective (constant low back pain radiating to the groin, hip, and left leg with numbness and tingling) and objective (tenderness to palpation over the lumbar paraspinal musculature with spasms, tenderness to palpation over the bilateral sacroiliac joints, decreased lumbar range of motion, positive straight leg raise bilaterally, and hypesthesia of the left lateral thigh) findings. Current diagnoses are lumbar spine sprain/strain with radiculitis and acute on chronic low back pain and treatment to date includes aquatic therapy, physical therapy, and medications (prior treatment with Soma). Regarding Carisoprodol 350MG, QTY 60, there is no documentation of acute exacerbation of chronic low back pain, an intention for short-term treatment, and functional benefit or improvement as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications as a result of use of Carisoprodol. Regarding chiropractic treatment with physiotherapy and myofascial release (QTY 6) it cannot be determined if this is a request for initial or additional chiropractic treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RANGE OF MOTION AND MUSCLE STRENGTH TESTING:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement Measures (7/18/2009).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Computerized range of motion (ROM)/Flexibility.

**Decision rationale:** MTUS does not address the issue. ODG identifies that computerized range of motion (ROM)/flexibility is not recommended as primary criteria and that the relation between back range of motion measures and functional ability is weak or nonexistent. Therefore, based on guidelines and a review of the evidence, the request for range of motion and muscle strength testing is not medically necessary.

**CARISOPRODOL 350MG, QTY 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that Carisoprodol (Soma) is not recommended and that this medication is not indicated for long term use. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of lumbar spine sprain/strain with radiculitis and acute on chronic low back pain. In addition, there is documentation of chronic low back pain. However, despite documentation of a diagnosis of acute on chronic low back pain, and given documentation of subjective findings (constant low back pain radiating to the groin, hip, and left leg with numbness and tingling), there is no (clear) documentation of acute exacerbation of chronic low back pain. In addition, given documentation of ongoing treatment with Carisoprodol and a request for Carisoprodol 350MG, QTY 60, there is no documentation of an intention for short-term (less than two weeks) treatment. Furthermore, given documentation of prior treatment with Carisoprodol, there is no documentation of functional benefit or improvement as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications as a result of use of Carisoprodol. Therefore, based on guidelines and a review of the evidence, the request for Carisoprodol 350MG, QTY 60 is not medically necessary.

**CHIROPRACTIC TREATMENT WITH PHYSIOTHERAPY AND MYOFASCIAL RELEASE, QTY 6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation (July 18, 2009) Page(s): 58-60.

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

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that manual therapy/manipulation is recommended for chronic pain if caused by musculoskeletal conditions, and that 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. MTUS additionally supports a total of up to 18 visits over 6-8 weeks. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar spine sprain/strain with radiculitis and acute on chronic low back pain. In addition, there is documentation of chronic pain caused by musculoskeletal conditions. Furthermore, given documentation of subjective (constant low back pain radiating to the groin, hip, and left leg with numbness and tingling) and objective (tenderness to palpation over the lumbar paraspinal musculature with spasms, tenderness to palpation over the bilateral sacroiliac joints, decreased lumbar range of motion, positive straight leg raise bilaterally, and hypesthesia of the left lateral thigh) findings, there is documentation that the intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement. However, given documentation of a 5/18/01 date of injury, where there would have been an opportunity to have had previous chiropractic treatment, it is not clear if this is a request for initial or additional (where chiropractic treatment provided to date may have already exceeded guidelines regarding a time-limited plan and there is the necessity of documenting functional improvement) chiropractic treatment. Therefore, based on guidelines and a review of the evidence, the request for chiropractic treatment with physiotherapy and myofascial release, QTY 6 is not medically necessary.