

<b>Case Number:</b>	CM14-0099875		
<b>Date Assigned:</b>	09/26/2014	<b>Date of Injury:</b>	03/22/2007
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	06/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 39-year-old female who reported an injury on 03/22/2007 due to slipping on a wet floor. Diagnoses were lumbar facet arthropathy and chronic lumbar pain. Past treatments were medications, chiropractic treatment, aqua therapy, and physical therapy. MRI, dated 07/02/2009, revealed L5 spondylosis with a 6 mm anterior subluxation of the L5 with respect to S1. Physical examination on 07/25/2014 revealed the injured worker complained that pain was worse. The injured worker rated the pain 7/10. The injured worker was doing water therapy on her own. Examination of the lumbar spine revealed tenderness to palpation over the right paraspinal. Range of motion for flexion was to 60 degrees, extension was to 25 degrees, right lateral flexion was to 25 degrees and left lateral flexion was to 25 degrees. Straight leg raise was negative bilaterally. Supine straight leg raise was negative bilaterally. Facet load test was negative. Lumbar facet stress test was positive on the right. Motor strength was normal for the upper and lower extremities at 5/5. Light touch sensation was intact at the L2-S1 dermatomes. Reflexes were 2/4 for patella and Achilles. Treatment plan was to continue water therapy and start chiropractic sessions, continue medications as directed. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

. (6) **Chiropractic visits:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy, Page(s): , page 58-59.

**Decision rationale:** The decision for 6 Chiropractic visits is not medically necessary. The California Medical Treatment Utilization Schedule states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For low back pain, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare ups requires a need for re-evaluation of prior of treatment success. Treatment is not recommended for the ankle and foot, carpal tunnel syndrome, the forearm, wrist, and hand or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of a subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks and at 8 weeks, patients should be re-evaluated. 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. The objective functional improvement was not reported from previous manual therapy sessions. The clinical documentation submitted for review does not provide evidence to justify 6 chiropractic visits. Therefore, this request is not medically necessary.

**Multi-Disciplinary Evaluation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Chronic Pain Programs, Page(s): 32.

**Decision rationale:** The decision for multidisciplinary evaluation is not medically necessary. The California Medical Treatment Utilization Schedule states that the criteria for the general use of multidisciplinary pain management programs are an adequate and thorough evaluation has been made, including baseline functional testing so followup with the same test can note functional improvement; previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; the patient has a significant loss of ability to function independently resulting from the chronic pain; the patient is not a candidate where surgery or other treatments would clearly be warranted; the patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; and negative predictors of success above have been addressed. The injured worker has not met the criteria set forth by the medical guidelines. The injured worker has not failed conservative treatment modalities. It was not reported that the injured worker had a significant loss of ability to function independently. The clinical information submitted for review does not provide enough evidence to warrant a multidisciplinary evaluation at this time. Therefore, this request is not medically necessary.

**60 Norco 5/325mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Norco, Ongoing Management, Page(s): page 75, 78.

**Decision rationale:** The decision for 60 Norco 5/325 mg is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend short acting opioids, such as Norco, for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. The 4 A's for ongoing management of an opioid medication were not reported. The request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

**60 Ibuprofen 600mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Page(s): , page 67.

**Decision rationale:** The decision for 60 ibuprofen 600 mg is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDs are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The request does not indicate a frequency for the medication. The efficacy of this medication was not reported. Therefore, this request is not medically necessary.

**60 Nortriptyline 25 mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): page 13.

**Decision rationale:** The decision for 60 Nortriptyline 25 mg is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an

objective decrease in pain and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration, and psychological assessments. The request does not indicate a frequency for the medication. The efficacy of this medication was not reported. Sleep quality and duration, and psychological assessments were not made for the injured worker. Therefore, this request is not medically necessary.