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**Notice of Independent Medical Review Determination**

Dated: 11/21/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/19/2013
Date of Injury:	3/22/2006
IMR Application Received:	7/30/2013
MAXIMUS Case Number:	CM13-0004614

- 1) MAXIMUS Federal Services, Inc. has determined the request for **chiropractic manipulation to cervical spine QTY: 9.00 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **massage therapy to cervical spine QTY: 9.00 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **retro Carisoprodol 305 MG (1/2) QTY: 30.00 DOS 7/9/13 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **retro Carisoprodol 305 MG (2/2) QTY: 30.00 DOS 7/9/13 is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Hydrocodonebit/APAP 10/325mg (1/2) QTY: 330.00 DOS 7/9/13 is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Hydrocodonebit/APAP 10/325mg (2/2) QTY: 330.00 DOS 7/9/13 is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/30/2013 disputing the Utilization Review Denial dated 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/9/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **chiropractic manipulation to cervical spine QTY: 9.00 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **massage therapy to cervical spine QTY: 9.00 is not medically necessary and appropriate.**
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- 5) MAXIMUS Federal Services, Inc. has determined the request for **Hydrocodonebit/APAP 10/325mg (1/2) QTY: 330.00 DOS 7/9/13 is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Hydrocodonebit/APAP 10/325mg (2/2) QTY: 330.00 DOS 7/9/13 is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

The patient is a 51-year-old female who reported an injury on 03/22/2006. She is reported to complain of neck pain and left radicular symptoms. She is noted to have treated previously for 16 sessions of massage therapy in 03/2013. She is reported to have had 75% relief lasting for greater than 2 months and then the return of her low back symptoms. The patient is noted to have been taking extra meds, and a note dated 04/16/2013 reported that the 1 Norco taken everyday was insufficient to control her symptoms. She was taking the medications twice a day. A clinical note dated

07/09/2013 reported that the patient continued to have neck pain radiating into the left greater than right upper extremities. She was reported to have had previous MRIs, which were reported to find disc herniations at multiple levels and a positive EMG/NCV. She was noted to have, on physical exam, decreased sensation in the left C5 and C6 dermatomes to palpation and positive tenderness of the cervical paraspinal muscles. She was noted to have started 9 sessions of chiropractic therapy in 08/2013.

#### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for chiropractic manipulation to cervical spine QTY: 9.00:**

##### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM Occupational Medicine Practice Guidelines, 2<sup>nd</sup> Edition, 2004, Chapter 8, pg. 173 regarding Neck and Upper Back Complaints, which is a part of MTUS.

The Expert Reviewer based his/her decision on the Neck & Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), online edition, Summary of Recommendations and Evidence Table 8-8, pg. 181-182, which is part of MTUS and Title 8 California Code of Regulations Definitions, which is a part of the MTUS.

##### Rationale for the Decision:

The California MTUS Guidelines state that manipulations are indicated as an option for patients with occupationally-related neck pain or cervicogenic headaches. Consistent with application of any passive manual approach, it is reasonable to incorporate it within the context of functional restoration rather than for pain control alone, and there is insufficient evidence to support manipulations for patients with cervical radiculopathy. The California MTUS Guidelines also recommend that there must be ongoing documentation of functional improvement by either clinically significant improvement in activities of daily living, a reduction on work restrictions or a reduction of dependency on continued medical treatment. The records reviewed indicate that the employee was noted to have been treated with chiropractic therapy in the past. There was no documentation that there was significant functional improvement with the use of chiropractic manipulations. In addition, manipulation for patients with cervical radiculopathy is not supported as there is insufficient evidence. **The request for chiropractic manipulation to the cervical spine QTY:9 is not medically necessary and appropriate.**

**2) Regarding the request for massage therapy to cervical spine QTY: 9.00 :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines pg. 60-Massage therapy, which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Medical Treatment Guidelines, Massage Therapy, pg. 60, which is a part of the MTUS.

Rationale for the Decision:

The California MTUS Guidelines state that this treatment should be an adjunct to other recommended treatments such as exercises and should be limited to 4 to 6 in most cases. A review of the records indicate that there is no indication that the employee is treating with exercise therapy, and as the employee is noted to have only temporary relief of cervical pain following the previous massage therapy, the requested additional massage therapy does not meet guideline recommendations and exceeds the number of visits recommended. **The request for massage therapy to the cervical spine QTY:9 is not medically necessary and appropriate.**

**3) Regarding the request for retro Carisoprodol 305 MG (1/2) QTY: 30.00 DOS 7/9/13 :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009) pg 29, which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Muscle relaxants, pg. 63, 65, which is a part of MTUS.

Rationale for the Decision:

The California MTUS Guidelines state that nonsedating muscle relaxants are recommended with caution as a second-line option for the short-term treatment of acute exacerbations in patients with chronic pain, and carisoprodol is recommended for no longer than a 2 to 3 week period. A review of the records indicate the employee appears to be taking the carisoprodol on an ongoing long-term basis, the request for retro carisoprodol does not meet guideline recommendations. **The request for retrospective Carisoprodol 350mg (1/2) QTY:30 is not medically necessary and appropriate.**

**4) Regarding the request for retro Carisoprodol 305 MG (2/2) QTY: 30.00 DOS 7/9/13:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009) pg 29, which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Muscle relaxants pg. 63, 65, a part of MTUS.

Rationale for the Decision:

The California MTUS Guidelines state that nonsedating muscle relaxants are recommended with caution as a second-line option for the short-term treatment of acute exacerbations in patients with chronic pain, and carisoprodol is recommended for no longer than a 2 to 3 week period. A review of the records indicate that the employee appears to be taking the carisoprodol on an ongoing long-term basis, the request for retro carisoprodol does not meet guideline recommendations. **The request for retrospective Carisoprodol 350mg (2/2) QTY:30 is not medically necessary and appropriate.**

**5) Regarding the request for Hydrocodonebit/APAP 10/325mg (1/2) QTY: 330.00 DOS 7/9/13**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pg. 80 a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, criteria for use pg. 78; Opioids for chronic pain, pg. 80 which are part of MTUS as well as Title 8 California Code of Regulations, section 9792.20. Medical Treatment Utilization Schedule—Definitions, “Functional improvement”, which is a part of MTUS.

Rationale for the Decision:

The California MTUS Guidelines recommend that there be ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects with the use of opioid analgesics. The pain assessment should include: current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioids, how long it takes for pain relief and how long pain relief lasts. Satisfactory response to treatment may be indicated by decreased pain levels, an increased level of function or improved quality of life. They recommend the use of opioids for neuropathic pain that has not responded to first-line recommendations with treatment of antidepressants or anticonvulsants and state that opioids for chronic neck pain appear to be efficacious but limited for short-term pain relief with long-term efficacy unclear but appearing to be limited. A review of the documents provided, there is no documentation that the employee receives any pain relief with the use of medications, nor is there documentation of improved functional

status or if the employee has been assessed for appropriate medication use or side effects, and there was no documentation as to what the pain decreases to after taking the opioid, and as there was no indication that the employee has not responded to first-line recommendations consisting of antidepressants or anticonvulsants. **The request for Hydrocodonebit/APAP 10/325mg (1/2) Qty: 330 is not medically necessary and appropriate.**

**6) Regarding the request for Hydrocodonebit/APAP 10/325mg (2/2) QTY: 330.00 DOS 7/9/13 :**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pg. 80 a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, criteria for use pg. 78; Opioids for chronic pain, pg 80 which are part of MTUS as well as Title 8 California Code of Regulations, section 9792.20. Medical Treatment Utilization Schedule—Definitions “Functional improvement”, which is a part of MTUS.

Rationale for the Decision:

The California MTUS Guidelines recommend that there be ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects with the use of opioid analgesics. The pain assessment should include: current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioids, how long it takes for pain relief and how long pain relief lasts. Satisfactory response to treatment may be indicated by decreased pain levels, an increased level of function or improved quality of life. They recommend the use of opioids for neuropathic pain that has not responded to first-line recommendations with treatment of antidepressants or anticonvulsants and state that opioids for chronic neck pain appear to be efficacious but limited for short-term pain relief with long-term efficacy unclear but appearing to be limited. A review of the documents provided indicate there is no documentation that the employee receives any pain relief with the use of medications, nor is there documentation of improved functional status or if the employee has been assessed for appropriate medication use or side effects, and there was no documentation as to what the pain decreases to after taking the opioid, and as there was no indication that the employee has not responded to first-line recommendations consisting of antidepressants or anticonvulsants. **The request for Hydrocodonebit/APAP 10/325mg (2/2) Qty: 330 is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.