

Case Number:	CM13-0010729		
Date Assigned:	12/27/2013	Date of Injury:	07/02/2002
Decision Date:	02/28/2014	UR Denial Date:	07/15/2013
Priority:	Standard	Application Received:	08/13/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & 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 physician 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:

This 50 year-old female sustained an injury on 7/2/02. Requests under consideration include physical therapy, massage therapy, and acupuncture. Injury to her neck resulted from moving a heavy phone switch while trying to open a cabinet. The patient had persistent radicular cervical pain with cervical MRI revealing multi-level disc protrusions. She failed conservative care which included therapy, medications, and cervical epidural steroid injections and underwent cervical discectomy and fusion at C5-6 and C6-7 on 1/10/06. She has moved to [REDACTED] and is under the care of [REDACTED], occupational medicine since February 2010 who have treated with acupuncture, physical therapy, trigger point injections, massage therapy, and prescribed medications of Lunesta, Effexor, and Vicodin. No subjective complaints are specified. Exam showed marked c-spine tenderness, reduced ROM, and upper extremity weakness right more so than left. Treatment requests above for PT, massage therapy, and acupuncture were non-certified on 7/15/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy (8 sessions): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received at least some therapy sessions per reports by physical therapist and clinic notes without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up and the patient has been instructed on a home exercise program for this injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The physical therapy (8 sessions) is not medically necessary and appropriate.

Massage therapy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

Decision rationale: Massage is recommended for time-limited use in subacute and chronic pain patients without underlying serious pathology and as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises; however, this is not the case for this 2002 injury status post significant conservative therapy. A short course may be appropriate during an acute flare-up; however, this has not been demonstrated nor are there any documented clinical change or functional improvement from treatment rendered previously. Without any new onset or documented plan for a concurrent active exercise program, criteria for massage therapy have not been established per MTUS Chronic Pain Guidelines. The massage therapy (8 sessions) is not medically necessary and appropriate.

Acupuncture (8 sessions): Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: MTUS, Acupuncture Guidelines recommend initial trial of conjunctive acupuncture visit of 3 to 6 treatment with further consideration upon evidence of objective functional improvement. It is unclear how many acupuncture sessions the patient has received for this 2002 injury. Submitted reports have not demonstrated the medical indication to support for additional acupuncture sessions as there are no specific objective changes in clinical findings, no report of acute flare-up or new injuries, neither is there any decrease in medication usage. Acupuncture (8 sessions) is not medically necessary and appropriate.