

Case Number:	CM14-0117608		
Date Assigned:	08/06/2014	Date of Injury:	12/17/1999
Decision Date:	10/03/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/28/2014

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 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 patient is a 56 year old female who sustained an industrial injury on 12/17/1999. Recent treatment to date has included 12-18 physical therapy sessions and 6 acupuncture treatments. According to the 2/24/2014 progress report, the patient complains of increasing cervical spine pain with radiation to her face and TMJ, and increased low back pain. On examination, there is 2+ cervical spine spasms with marked tenderness to palpation to trapezius and paracervical musculature bilaterally. Cervical and lumbar ROM are decreased, there is marked tenderness to palpation of over bilateral SI joint and paravertebral musculature. Treatment plan indicates acupuncture has helped in the past, recommendation is for acupuncture and chiropractic/physical therapy 2-3 times a week for 4-6 weeks, right L5-S1 facet injection and right C5-6 facet injection. The patient's work status is TTD. Per the 6/9/2014 orthopedic re-evaluation report, the patient complains of cervical spine pain with radiation to her face and TMJ. She has increased pain with eating and chewing and has severe ear pain. She also complains of increased back pain. She has started PT and is paying for treatment herself, and notes improvement in pain level since starting therapy. Objective examination findings document 2+ cervical spine spasms with marked tenderness to palpation to trapezius and paracervical musculature bilaterally. Cervical ROM decreased in flexion and extension with greater pain on extension. Neurological examination is WNL. Lumbar spine has marked tenderness to palpation of over bilateral SI joint and paravertebral musculature. Lumbar ROM is decreased. Diagnoses are sprain of neck and lumbar spine. Treatment plan is chiropractic/physical therapy and acupuncture 3x week for 4-6 weeks. Work status is TTD.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment for cervical and lumbar spine QTY 24.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation, Physical Medicine Page(s): 58-59 98-99.

Decision rationale: The CA MTUS guidelines recommend Manual therapy & manipulation for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. 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. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. The patient is more than 14 years post industrial injury date. She has undergone extensive treatment to date. There is no mention of active utilization of any self-care plan, HEP, self-management of her remote injury. The medical records do not establish the patient had reduction in pain and increased function with prior physical therapy/chiropractic. Objective examination findings on 2/24/2014 and 6/9/2014 are unchanged, and she reports increasing pain. In the absence of objective functional improvement additional treatment is not supported, and is not medically necessary.

Physical Therapy for cervical and lumbar spine QTY 24.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

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

Decision rationale: The CA MTUS guidelines state patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. The patient is more than 14 years post industrial injury date. She has undergone extensive treatment to date. There is no mention of active utilization of any self-care plan, HEP, self-management of her remote injury. The medical records do not establish the patient had reduction in pain and increased function with prior physical therapy. Objective examination findings on 2/24/2014 and 6/9/2014 are unchanged, and she reports increasing pain. At this juncture, this patient should be well-versed in an independently applied home exercise program, with which to address residual

complaints, and maintain functional levels. In absence of clear findings of clinically significant functional deficits such as to establish an exacerbation unresponsive to self-care measures, additional supervised therapy is not supported. Additionally, in the absence of objective functional improvement additional treatment is not supported, and is not medically necessary.

Acupuncture Cervical ad Lumbar Spine QTY 24.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the CA MTUS guidelines, (c) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments.(2) Frequency: 1 to 3 times per week.(3) Optimum duration: 1 to 2 months.The patient has received at least 6 Acupuncture treatments. However, there is not documented evidence of functional improvement with rendered Acupuncture. Therefore, additional treatment is not supported, and is not medically necessary.

Right Lumbar Facet Block L5-S1 level QTY 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet Injections; Facet joint pain, signs & symptoms

Decision rationale: The CA MTUS/ACOEM guidelines state, "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit." According to the Official Disability Guidelines, lumbar facet joint blocks as therapeutic injections, are not recommended, and may only be considered as a diagnostic tool. There is minimal evidence for use as treatment. The medical records do not document clinical findings that support the existence of facet-mediated pain. The medical necessity of the request has not been established, and therefore is not supported.

Right Cervical Facet Block C5-6 QTY 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Facet joint pain, signs & symptoms; Facet Joint Diagnostic Blocks

Decision rationale: According to the CA MTUS/ACOEM guidelines, under the summary of recommendations for evaluating and managing neck and upper back complaints, facet injection of corticosteroids and diagnostic blocks are not recommended. According to the Official Disability Guidelines, cervical facet blocks are recommended prior to facet neurotomy, a procedure that is currently considered under study. Facet injections for therapeutic purposes are not recommended. For consideration of this procedure, certain criteria need to be met, such as signs and symptoms consistent with facet-mediated pain. In the case of this patient, the medical records do not document the existence of signs and symptoms consistent with facet mediated pain. Consequently, the medical records do not establish the request for cervical facet injection is appropriate or medically indicated for the treatment of this patient. The request is not medically necessary.