

Case Number:	CM14-0168598		
Date Assigned:	10/16/2014	Date of Injury:	07/09/2013
Decision Date:	11/19/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/13/2014

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 Internal Medicine, and is licensed to practice in Arizona. 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 48 year old man with a work-related injury dated 7/9/13 resulting in chronic back and shoulder pain. The office visit dated 9/3/14 with the primary provider noted the patient complains of arm/hand pain as well as neck and low back pain. The exam showed decreased range of motion of the cervical, lumbar, shoulder and right wrist with paraspinal spasms. There was decreased sensation in the C6 dermatome. The diagnosis included cervical and lumbar radiculopathy, CTS, RTC tear and shoulder impingement. The plan of care included chiropractic treatments 8 visits, aquatherapy 12 sessions, acupuncture 8 visits and pain management for lumbar injections. Under consideration is the medical necessity for chiropractic visits x 8 and aquatherapy x 12 sessions which were denied during utilization review on 9/16/14. The utilization review modified the request for acupuncture from 8 visits to 6 visits and the pain management for lumbar injections to pain management for consultations.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment For Lumbar Spine And Left Shoulder: Two (2) Times A Week For Four (4) Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: According to the MTUS manual therapy and manipulation is recommended 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. With regards to the low back, manipulation is recommended as an option for a trial of 6 visits over 2 weeks, with evidence of objective functional improvement. With regards to the treatments of ankle and foot conditions, CTS, forearm, wrist and hand and knee pain manipulation is not recommended. In this case the diagnosis includes cervical and lumbar radiculopathy, CTS, RTC tear and shoulder impingement. The only diagnosis in which the MTUS recommends manual manipulation is low back pain and for an initial trial of 6 treatments over 2 weeks. The requested Chiropractic Treatment For Lumbar Spine And Left Shoulder: Two (2) Times A Week For Four (4) Weeks is not medically necessary.

Acupuncture Treatment For Lumbar Spine And Left Shoulder: Two (2) Times A Week For Four (4) Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: According to ACOEM with regards to low back pain, acupuncture has not been found effective in the management of back pain, based on several high-quality studies. The use of acupuncture is not medically necessary.

Aqua Therapy Twelve (12) Sessions, Lumbar Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: According to the MTUS aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable. The recommendations on the number of supervised visits are equivalent with the number of visits with physical medicine. In this case

there is no documented reason the patient can not perform land-based physical therapy or a home exercise program. The Aqua Therapy is not medically necessary.

Pain Management For Lumbar Injections: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM for Independent Medical Examinations and Consultations regarding Referrals, Chapter 7

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: According to the MTUS epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. Criteria for the use of ESI is 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDS, and muscle relaxants). Injections should be performed using fluoroscopy for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. 5) No more than two nerve root levels should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. In this case the type of "lumbar injections" is not specified. As the provider is referring to a pain specialist and has not corroborated the physical findings of radiculopathy with imaging studies and/or electrodiagnostic testing. The request for Pain Management For Lumbar Injections is not medically necessary.