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| Case Number: | CM14-0038370 | | |
| Date Assigned: | 06/25/2014 | Date of Injury: | 10/11/2010 |
| Decision Date: | 10/15/2014 | UR Denial Date: | 03/17/2014 |
| Priority: | Standard | Application Received: | 04/01/2014 |

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 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 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 is a 48-year-old female with a 10/11/10 date of injury. A specific mechanism of injury was not described. According to a progress report dated 6/17/14, the patient continued to complain of cervical pain to right upper extremities. She is status post C3-C7 Anterior Cervical Discectomy and Fusion on 10/28/13. Objective findings: cervical spine spasms and decreased range of motion. Diagnostic impression: displacement intervertebral disc site without myelopathy. Treatment to date: medication management, activity modification, physical therapy, surgery. A UR decision dated 3/17/14 denied the request for continued physical therapy with massage 3 x wk for 6 wks. There is no documentation of exceptional indications for a therapy extension or reasons why a prescribed independent home exercise program would be insufficient to address any remaining functional deficits. Regarding evaluation and treatment with trigger point injection, there is no evidence of the need for trigger point injection including upon palpation of a twitch response or referred pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy with massage 3x6:

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines General Approaches Page(s): 98-99. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function Chapter 6 page 114

Decision rationale: CA MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Physical Medicine Guidelines - Allow for fading of treatment frequency. It is noted that the patient has had previous physical therapy. However, It is unclear how many sessions he has had in total. There is no documentation of functional improvement or gains in activities of daily living from the prior physical therapy sessions. In addition, it is unclear why the patient has not been able to transition to an independent home exercise program at this time. Therefore, the request for Physical Therapy with massage 3x6 was not medically necessary.

Referral for Eval and treatment with trigger point injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

Decision rationale: MTUS criteria for trigger point injections include chronic low back or neck pain with myofascial pain syndrome with circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; symptoms for more than three months; medical management therapies have failed; radiculopathy is not present; and no more than 3-4 injections per session. Additionally, repeat injections are not recommended unless greater than 50% pain relief has been obtained for six weeks following previous injections, including functional improvement. There is no documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. In addition, there is no documentation that the patient has failed conservative therapy.