

Case Number:	CM14-0040969		
Date Assigned:	06/27/2014	Date of Injury:	12/03/2010
Decision Date:	08/16/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	04/07/2014

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 Anesthesiology has a subspecialty in Pain Medicine 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 injured worker is a 56 year old female whose date of injury is 12/03/2010. The mechanism of injury is described as helping a client lay down on a mat. She noted low back pain. 01/21/11 magnetic resonance image of the thoracic spine noted mild degenerative disc disease throughout the thoracic spine, moderate degenerative disc disease throughout the thoracic spine, Schmorl nodes; costovertebral and facet degenerative joint changes along the spine. Note dated 01/15/14 indicates that the injured worker is seen by two psychologists. Progress note dated 03/18/14 indicates that the injured worker complains of neck and right upper extremity pain. It is noted that the injured worker is approaching maximum medical improvement. Diagnoses are bilateral shoulder pain and thoracic spine degenerative disc disease. It is reported that the injured worker completed functional restoration program on 10/25/13. She has completed 2 of 4 authorized acupuncture sessions. Treatment to date also includes thoracic medial branch blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurology Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Treatment & Workman's Compensation (TWC): Evaluation and Management.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127.

Decision rationale: The previous request was denied on the basis that the clinical information submitted indicates that the injured worker has persistent pain complaints in the shoulder and thoracic spine. The injured worker recently completed an East Bay Functional Restoration on 10/25/13 and reported benefit with regard to pain coping skills. Approval of such a program would indicate that the injured worker had failed all prior treatments and was not a candidate for further treatment. There was no report of a new acute injury or exacerbation of previous symptoms that would warrant a new specialty evaluation. Therefore, the request for Neurology Consultation is not medically necessary and appropriate.

Cognitive Behavioral Therapy, QTY: 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive Behavioral Therapy (CBT) Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23.

Decision rationale: The submitted records indicate that the injured worker has undergone extensive psychological treatment including psychotherapy and functional restoration program. The injured worker's objective functional response to this treatment is not documented. California Medical Treatment Utilization Schedule guidelines support up to 10 visits of cognitive behavioral therapy. There are no current psychometric testing measures provided. Therefore, the request for Cognitive Behavioral Therapy, qty: 6 is not medically necessary and appropriate.

Acupuncture QTY: 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule states that an initial regimen of three to six treatments may be used as an adjunct to conservative treatment and with evidence of significant functional improvement, treatments may be extended. The injured worker's response to prior acupuncture is not provided to establish efficacy of treatment and support additional sessions. Based on the clinical information provided, the request for acupuncture x 6 is not recommended as medically necessary.