

Case Number:	CM14-0096231		
Date Assigned:	07/25/2014	Date of Injury:	07/01/2013
Decision Date:	08/28/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	06/24/2014

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 & Rehabilitation, and is licensed to practice in Illinois. 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 34-year-old male who reported an injury on 07/01/2013 due to being hit by a heavy loaded crane full of steel castings. On 06/05/2014 he reported pain in the back associated with weakness in his upper extremities and described as moderate to severe. He also reported midback pain along with stiffness in the neck along the cervical spine and paracervical area. A physical examination of the thoracic spine revealed tenderness to the left side of the paravertebral muscles, diminished thoracic range of motion and pain on extension of the thoracic spine along with pain in the right erector spinae group. Examination of the cervical and lumbar spine revealed to be normal with the exception of diminished cervical range of motion. A motor and sensory examination revealed to be normal as well. He had an MRI of the lumbar spine performed on 08/21/2013, that showed no significant disc pathology and no compromise of the spinal canal lateral recess or the intervertebral foramina and an EMG performed on 02/24/2014 had negative findings of radiculopathy or peripheral neuropathy. There is no documentation stating that the injured worker had received surgery for his injuries. His diagnoses were listed as spasm of the muscle, sprain/strain of the thoracic region, and cervicgia. Medications were not provided for review. Past treatments included chiropractic therapy, 2 sessions of physical therapy, and medications. The treatment plan was for 8 sessions of acupuncture and 8 sessions of physical therapy to the thoracic spine. The Request for Authorization Form was signed on 06/05/2014. The rationale for treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture QTY 8.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for Acupuncture quantity 8 is non-certified. On 06/05/2014, the injured worker reported back/midback pain and stiffness in the neck along the cervical spine and paracervical area. It was stated that most of his pain was between the shoulder blades and radiated up to the cervical spine. A physical examination of the cervical and lumbar spine revealed to be normal with the exception of diminished cervical range of motion and pain along the suboccipital and paracervical area to palpation. Examination of the thoracic spine revealed tenderness along the left side of the paravertebral muscles and diminished thoracic range of motion and pain on extension. Motor, sensory, and reflex examinations all revealed to be within normal limits. The California Acupuncture Treatment Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten a functional recovery. Time to produce improvement is 3 to 6 treatments with a frequency of 1 to 3 times per week and an optimum duration of 1 to 2 months. Acupuncture sessions may be extended if functional improvement is documented. Based on the clinical information submitted for review, acupuncture treatment does not appear to be medically necessary. There is a lack of documentation regarding significant functional deficits and/or evidence that the injured worker was no tolerating pain medications or that medications were being reduced. Furthermore, the rationale for acupuncture therapy rather than physical therapy or other conservative treatment options is unclear. The request is not supported by the guideline recommendations as there is no evidence to indicate it's necessity. Given the above, the request for Acupuncture is not medically necessary.

Physical Therapy to thoracic spine QTY 8.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regional Sympathetic Blocks Page(s): 103-104.

Decision rationale: The request for Physical Therapy to the thoracic spine quantity 8 is non-certified. Per the Clinical Note dated 06/05/2014, the injured worker reported midback/back pain with stiffness in the neck and pain along the cervical spine and paracervical area. It was stated that most of his pain was between the shoulder blades and radiated up to the cervical spine. It was also noted that he felt no relief from chiropractic therapy and physical therapy sessions that he had attended. The California MTUS Guidelines state that physical therapy for myalgia and myositis unspecified is recommended for a total of 9 to 10 visits over 8 weeks, and for neuralgia, neuritis and radiculitis unspecified a total of 8 to 10 visits over 4 weeks is recommended.

Treatment frequency should be faded plus active self-directed home physical medicine should be implemented. Based on the clinical information submitted for review, the injured worker had stated that he felt no relief from the 2 physical therapy sessions he had completed. There was no documentation showing objective functional improvement with the completed sessions. In addition, the request for physical therapy to the thoracic spine is unclear as the injured worker reported that the majority of his pain was located in the cervical area. Furthermore, there are no significant functional deficits of the thoracic spine to indicate the need for additional physical therapy. The request is not supported by the guideline recommendations as there are no significant functional deficits documented, physical therapy for the thoracic area is unclear, and previously attended sessions had not been beneficial. Given the above, the request for Physical Therapy is not medically necessary.