

Case Number:	CM14-0053879		
Date Assigned:	07/07/2014	Date of Injury:	01/24/2013
Decision Date:	01/02/2015	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	04/22/2014

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 Acupuncture & Pain Medicine 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:

29 year old male injured worker with date of injury of 1/24/13. Injury related with neck and mid back pain. Per progress report dated 2/26/14, the injured worker rated his neck pain 5/10 in intensity without medication and 4/10 with medication. Mid back pain was rated 5/10 without medication and 4/10 with medication. Per physical exam, there was nuchal tenderness bilaterally, tenderness and myospasm over the bilateral paracervical muscles and bilateral trapezius muscles. Positive bilateral Spurling's and cervical distraction test were present. Cervical range of motion was decreased in all planes due to pain. Treatment to date has included trigger point injections, chiropractic manipulation, physical therapy, and medication management. The date of UR decision was 3/14/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2-3 x 6, Cervical and Thoracic Spine: 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): 309, Acupuncture Treatment Guidelines.

Decision rationale: Per Acupuncture Medical Treatment 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.(d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20" The MTUS definition of functional improvement is as follows: "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment." With regard to acupuncture, ACOEM states "Acupuncture has not been found effective in the management of back pain, based on several high-quality studies, but there is anecdotal evidence of its success." ACOEM p309 gives needle acupuncture an optional recommendation for evaluating and managing low back complaints. The guidelines recommend 3-6 treatments to produce functional improvement, and consider extension if functional improvement is then documented. As the request is for 12-18 sessions, it is in excess of the guidelines. It should be noted that the UR physician has certified a modification of the request for six sessions. The request is not medically necessary.

Chiropractic Therapy 2-3 x 6 Cervical and Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

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

Decision rationale: Per the MTUS guidelines with regard to chiropractic therapy: 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. The documentation submitted for review indicates that the injured worker has previously been treated with chiropractic therapy. The guidelines state that chiropractic care for flare-ups requires "documentation of previous treatment success." The documentation does not contain evidence of maintained functional improvement. As such, the request for additional chiropractic therapy is not medically necessary.