

Case Number:	CM15-0106374		
Date Assigned:	06/15/2015	Date of Injury:	07/24/2014
Decision Date:	08/21/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	06/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York, Tennessee

Certification(s)/Specialty: Emergency Medicine

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 41-year-old male, who sustained an industrial injury on 07/24/2014. He has reported subsequent neck and back pain and was diagnosed with cervical radiculitis, cervical and thoracic sprain/strain and thoracic myospasm. Treatment to date has included medication, physiotherapy, chiropractic care and acupuncture. In a progress note dated 03/11/2015, the injured worker complained of neck and back pain. Objective findings were notable for decreased range of motion of the cervical spine, tenderness to palpation of the bilateral trapezii and cervical paravertebral muscles, muscle spasms of the bilateral trapezii and cervical paravertebral muscles, positive cervical compression test, tenderness to palpation of the thoracic paravertebral muscles, muscle spasm of the thoracic paravertebral muscles and positive Kemp's test. A request for authorization of range of motion test, once a month per doctor's visit, acupuncture treatment, once a week for six weeks, chiropractic treatment once a week for six weeks and physical therapy once a week for six weeks was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Range of motion test, once (1) a month per doctor's visit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Flexibility.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Flexibility.

Decision rationale: Range of motion testing is a measure of flexibility. Flexibility is not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The request is not medically necessary.

Acupuncture treatment, once (1) a week for six (6) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Section 9792.24.1 of the California Code of regulations states that Acupuncture is used as an option when pain medication is reduced or not tolerated or as an adjunct to physical rehabilitation. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Acupuncture with electrical stimulation is the use of electrical current on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. Specific indications for treatment of pain include treatment of joint pain, joint stiffness, soft tissue pain and inflammation, paresthesias, post-surgical pain relief, muscle spasm and scar tissue pain. OGD states that acupuncture is not recommended for acute back pain, but is recommended as an option for chronic low back pain in conjunction with other active interventions. Acupuncture is recommended when use as an adjunct to active rehabilitation. 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. Acupuncture treatments may be extended if functional improvement is documented. In this case the patient had prior treatment with acupuncture. There is no documentation of the number of treatment or objective evidence of functional improvement. The request is not medically necessary.

Chiropractic treatment, once (1) a week for six (6) 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 Pain Interventions and Guidelines Page(s): 58.

Decision rationale: Manual therapy and evaluation are 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. Recommended treatment parameters are as follows: Time to produce effect 4-6 treatments, frequency of 1-2 times per week with maximum duration of 8 weeks. In this case, the patient had prior treatment with physical therapy and chiropractic treatment from September 2014 through November 2014. There is no documentation of objective evidence of functional improvement. The request is not medically necessary.

Physical therapy, once (1) a week for six (6) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine; Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 98-99.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Recommended number of visits for myalgia and myositis is 9-10 visits over 8 weeks; and for neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks. In this case, the patient has received physical therapy and chiropractic treatment 3 times weekly from September 2014 to November 2014. The number of prior visits surpasses the maximum recommended number of 10. In addition there is no documentation of objective evidence of functional improvement. The request is not medically necessary.