MAXIMUS Federal Services

Case Number:	CM15-0086850		
Date Assigned:	05/11/2015	Date of Injury:	04/07/2014
Decision Date:	06/19/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	05/06/2015

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: Arizona, Texas
Certification(s)/Specialty: Internal 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:

This is a 59 year old male with an April 7 2014 date of injury. A progress note dated March 3, 2015 documents subjective findings (neck pain rated at a level of 6/10 without medications and 4/10 with medications; neck pain associated with occasional radiation to the right arm; lower back pain rated at a level of 6/10 without medications and 4/10 with medications; lower back pain associated with occasional radiating pain to the right lower extremity; right shoulder pain rated at a level of 6/10 without medications and 4/10 with medications), objective findings (decreased and painful range of motion of the cervical spine; tenderness to palpation of the cervical paravertebral muscles; decreased and painful range of motion of the lumbar spine; tenderness to palpation of the lumbar paravertebral muscles; decreased and painful range of motion of the right shoulder; tenderness to palpation of the acromioclavicular joint, anterior shoulder, glenohumeral joint lateral shoulder, posterior shoulder, and trapezius), and current diagnoses (cervical sprain/strain; lumbar sprain/strain; rotator cuff sprain/strain). Treatments to date have included medications, x-rays of the lumbar spine (showed severe L4-L5 degenerative changes), and physical therapy. The treating physician documented a plan of care that included acupuncture and chiropractic treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture therapy 2 times per week for 3 weeks, unspecified: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. 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 (microamperageor milli-amperage) 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. In this case, the Patient has chronic pain and has been treated with analgesic medications and therapy. The treatment that was approved on 4/8/15 included 6 chiropractic treatments. The documentation does not provide details if this patient had these treatments and if they were effective. Given the lack of details regarding the approved services, the documentation does not support the medical necessity for acupuncture.

Chiropractic therapy 2 times per week for 3 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 9792.20-.26 Page(s): 58-60.

Decision rationale: According to the MTUS, manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. With regards to low-back pain it is recommended as an option for a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. In this case, a separate request for treatment was submitted on 3/17/15 for 6 sessions of chiropractic care. The requested chiropractic treatments were approved, however, the documentation does not give details if the IW had these sessions and if they were effective. Given the lack of documentation regarding the services approved (6 sessions of chiropractic treatment) on 4/8/15, the current services are not medically necessary.