

Case Number:	CM14-0124082		
Date Assigned:	09/29/2014	Date of Injury:	06/15/1998
Decision Date:	11/05/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/05/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 47-year-old female with a reported date of injury of 06/15/1998. The mechanism of injury was not listed in the records provided. The diagnoses included cervical intervertebral disc (IVD) degeneration, brachial neuritis, and thoracic segmental dysfunction. The past treatments included massage therapy and chiropractic therapy. There was no diagnostic testing documented in the notes. There was no surgical history documented within the records. The subjective complaints on 07/11/2014 included neck pain, upper back pain, and headaches. The physical examination noted generally decreased range of motion to the cervical spine. Muscle spasms were also noted in the right C6 through C7. Tenderness on palpation was found in the right scapula. The medications were not documented within the clinical note. The treatment plan was to perform chiropractic therapy, mechanical traction, and acupuncture therapy. A request was received for chiropractic 1 to 3 treatments, including myofascial release, mechanical traction, and acupuncture 1 time a month for cervical and thoracic spine. The rationale for the request was not provided within the records. The Request for Authorization form was not provided within the clinical notes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 1-3 treatments including myofascial release, mechanical traction: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, 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: The request for chiropractic 1 to 3 treatments including myofascial release and mechanical traction is not medically necessary. The California MTUS Guidelines state that manual therapy and manipulation is recommended as an option to treat low back pain. An initial trial of 6 visits is supported and continued visits should be contingent upon documentation of objective functional improvement. In order for the initial trial of 6 visits to be supported, there should be clear documented evidence of functional deficits on the physical examination. The physical examination noted decreased cervical range of motion; however, it did not provide any objective range of motion values to objectively determine the functional deficits of the injured worker. In the absence of functional deficits (i.e., decreased range of motion or decreased motor strength), the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Acupuncture 1 time a month for cervical and thoracic spine: 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 1 time a month for cervical and thoracic spine is not medically necessary. The California Acupuncture Medical Treatment Guidelines state that acupuncture is indicated to treat chronic pain conditions, radiating pain along nerve pathways, muscle spasm, inflammation, scar tissue pain, and pain located at multiple sites. The guidelines also stated that the recommended frequency is 1 to 3 times per week with an optimum duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented in the clinical notes. The injured worker has chronic pain. The request for acupuncture would be appropriate for the injured worker; however, the request as submitted did not include a frequency or duration. In the absence of a frequency and duration, it is not known how many times per week, how many sessions, or how long the intended therapy to be performed. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.