

Case Number:	CM15-0112562		
Date Assigned:	06/19/2015	Date of Injury:	10/24/2014
Decision Date:	08/24/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	06/11/2015

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:

The injured worker is a 51-year-old male, who sustained an industrial/work injury on 8/26/11. He reported initial complaints of neck pain. The injured worker was diagnosed as having cervical disc displacement, brachial neuritis, cervical spinal stenosis, cervical syndrome, thoracic lumbar disc displacement, lumbar sprain, neurotic depression and sleep disturbance. Treatment to date has included medication, diagnostic testing, and surgery (three level anterior cervical discectomy). MRI results were reported on 1/6/15 to report acute anteroinferior T10 endplate inflammation and spondylosis deformans at T10-11, no posterior disc protrusion, canal stenosis, or neuroforaminal encroachment. The cervical MRI on 1/10/15 reported 5 mm left paracentral C5-6 disc herniation stenosing spinal canal, compressing the cervical cord, encroaching the right > left neuroforamen and impinging the right nerve root exacerbated by marked disc degeneration, desiccation and spondylosis deformans, 4 mm right paracentral C6-7 disc herniation encroaching the right > left neuroforamen and impinging the right nerve root, and 3 mm C3-4 and C 4-5 protrusions elevating the posterior longitudinal ligament encroaching the neuroforamen and stenosing the spinal canal at C4-5. Currently, the injured worker complains of neck pain rated 7/10. Per the primary physician's progress report (PR-2) on 4/6/15, examination noted moderate spasticity and tenderness (R>L) over the paracervical musculature, decrease in range of motion by 10%, positive foraminal compression test, positive distraction test, discrepancies in sensory and reflex, flexion and extension revealed pain and discomfort, discrepancies in girth measurements. The requested treatments include transcutaneous electrical nerve stimulation (TENS) unit and supplies (rental or purchase).

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient hour physiotherapy sessions, two (2) times a week, for 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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

Decision rationale: According to the MTUS, passive therapy can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. Physical Medicine Guidelines state that it should be allowed for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. In this case, the patient has been treated previously with physical therapy without documented functional improvement. This request is not medically necessary.

Acupuncture treatment eight (8) sessions, two (2) times a week for four (4) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the MTUS, 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. In this case, the patient has previously had acupuncture. The number of treatments is not documented and functional improvement with prior treatments is not documented. The medical necessity for further acupuncture is not made. This request is not medically necessary.

Chiropractic treatment eight (8) sessions, two (2) times a week for four (4) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 7, 30.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: 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, the patient has had prior treatments that include chiropractic care. The documentation does not support that the patient has had functional improvement with previous treatments. The medical necessity for additional chiropractic sessions is not made. This request is not medically necessary.

Aquatic therapy twelve (12) two times a week for six (6) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Aquatic therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: According to the MTUS, aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable. The recommendations on the number of supervised visits are equivalent with the number of visits with physical medicine. In this case, the documentation does not support that the patient is unable to participate in traditional PT. Furthermore, the patient has been treated with therapy without documented functional improvement. This request is not medically necessary.