

Case Number:	CM15-0023197		
Date Assigned:	02/12/2015	Date of Injury:	12/03/2010
Decision Date:	06/05/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	02/06/2015

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: Texas, Oklahoma

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 66-year-old female, who sustained an industrial injury on 12/03/2010. She reported falling from a chair on which she was standing, subsequently hitting her head on the floor. The injured worker was diagnosed as having myofascial pain. Treatment to date has included medications, and trigger point injection. The request is for chiropractic evaluation of the cervical spine, initial chiropractic treatment, x-ray of the cervical spine, and Lidoderm 5% patches. The injured worker presented on 12/12/2014 for a follow-up evaluation regarding neck pain. The injured worker reported multiple psychiatric symptoms to include anxiety, depression, crying episodes, and feelings of worthlessness. Upon examination, the physician noted the injured worker was less labile with a depressed mood. The injured worker's thought content was less anxious and depressive, consistent with the mood and circumstances. There was no thought disorder noted. The injured worker was diagnosed with depressive disorder, panic disorder, and cognitive disorder due to traumatic brain injury. The injured worker was instructed to continue with the current medication regimen of Wellbutrin, Ambien, and Xanax. A Request for Authorization form was submitted on 01/20/2015 for chiropractic treatment 3 times per week for 4 weeks for the cervical spine with multiple CPT Codes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Evaluation for the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58. Decision based on Non-MTUS Citation ODG-TWC Neck & Upper Back Procedure Summary, Chiropractic Guidelines.

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

Decision rationale: California MTUS Guidelines recommend manual therapy and manipulation for chronic pain if caused by a musculoskeletal condition. Treatment is recommended as a therapeutic trial of 6 visits over 2 weeks. As the injured worker's course of chiropractic treatment has not been authorized, the associated request for the chiropractic evaluation is not medically necessary.

Initial Chiropractic Treatment (12-sessions, 3 times a week for 4 weeks for the cervical spine): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58. Decision based on Non-MTUS Citation ODG-TWC Neck & Upper Back Procedure Summary, Chiropractic Guidelines.

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

Decision rationale: California MTUS Guidelines recommend manual therapy and manipulation for chronic pain if caused by a musculoskeletal condition. Treatment is recommended as a therapeutic trial of 6 visits over 2 weeks. The current request for 12 sessions of chiropractic treatment for the cervical spine exceeds guideline recommendations. Therefore, the request is not medically necessary.

X-Ray of the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation ODG-TWC Neck & Upper Back Procedure Summary, Indications for Imaging.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: California MTUS/ACOEM Practice Guidelines state for most patients presenting with true neck and upper back problems, special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. In this case, there is no recent comprehensive physical examination of the cervical spine provided. There is no mention of an attempt at any conservative management prior to the request for an x-ray of the

cervical spine. As the medical necessity has not been established, the request is not medically appropriate at this time.

Lidoderm 5% Patch: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Anaglesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Anaglesics Page(s): 111-113.

Decision rationale: California MTUS Guidelines recommend lidocaine for neuropathic pain or localized peripheral pain after there has been evidence of a trial of first line therapy with an antidepressant or an anticonvulsant. In this case, there is no mention of a trial and failure of first line oral medication prior to the initiation of topical lidocaine. There is also no frequency or quantity listed. Given the above, the request is not medically necessary.