MAXIMUS Federal Services

Case Number:	CM15-0060661		
Date Assigned:	05/04/2015	Date of Injury:	09/11/2009
Decision Date:	06/02/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/30/2015

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
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 46 year old female, who sustained an industrial injury on 09/11/2009. On 04/19/2014, the injured worker underwent C5-6 and C6-7 anterior cervical discectomy and fusion. Following the surgery, she continued to have cervical spine pain with radiating symptoms in both upper extremities and difficulty swallowing. According to a progress report dated 02/17/2015, the injured worker could not sleep. Cervical spine epidural blocks in the past did not help. The provider noted that the injured worker would try marijuana cookies. Treatment with a spinal cord stimulator was discussed. The location and description of pain was not documented in the report. Diagnoses included status post fall with trauma to forehead; no loss of consciousness, posttraumatic head syndrome, headaches, lightheadedness and mood changes, chronic cervical spine strain, exacerbation of cervical spine pain, bilateral shoulder strain, chronic bilateral elbow strain with medial epicondylitis, bilateral wrist strain, depressive disorder and history of irritable bowel syndrome. Treatment to date has included medications, epidurals, TENS unit, MRI, cervical discectomy and fusion and electrodiagnostic testing. Treatment plan included chiropractic treatment and Polar Frost. Currently under review is the request for chiropractic treatment to the cervical spine, scapula and thoracic spine and Polar Frost.

IMR ISSUES, DECISIONS AND RATIONALES

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

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

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines: Chiropractic Manipulation.

Decision rationale: Per the ACOEM Guideline citation above, Chiropractic manipulation is a treatment option during the acute phase of injury, and manipulation should not be continued for more than a month, particularly when there is not a good response to treatment. Per the MTUS, chronic pain section citation listed above, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks, with any further manual therapy contingent upon functional improvement. The intended goal or effect 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. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, the requested number of sessions (12) exceeds the Guideline recommendation. Medical necessity for the requested service is not established. The requested service is not medically necessary.

Polar Frost (topical): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating Polar Frost. There is no documentation of intolerance to other previous medications. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.