MAXIMUS Federal Services

Case Number:	CM15-0074276		
Date Assigned:	04/24/2015	Date of Injury:	11/29/2013
Decision Date:	05/27/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/20/2015

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: California
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 44-year-old female who sustained an industrial injury on 11/29/2013. The injured worker was diagnosed with thoracic sprain/strain, right shoulder impingement syndrome and carpal tunnel syndrome. Treatment to date includes thoracic spine magnetic resonance imaging (MRI) on February 25, 2015 and bilateral upper extremities Electromyography (EMG)/Nerve Conduction Velocity (NCV) studies and March 20, 2015, chiropractic therapy, conservative measures and medications. According to the primary treating physician's progress report on March 6, 2015, the injured worker continues to experience intermittent upper/mid back pain radiating to the neck and rated as unchanged at 5/10. The right shoulder pain is worse and radiates down the arm to the hands and fingers associated with numbness and tingling. Her right hand pain is rated at 6/10. Exam of the right shoulder demonstrated tenderness to palpation of the anterior and posterior shoulder with supraspinatus press causing pain. Current medication is Ibuprofen. Treatment plan consists of orthopedic referral and the current request for chiropractic therapy and acupuncture therapy to the thoracic spine and right shoulder and Biofreeze.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biofreeze #1 Tube: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Biofreeze and Cryotherapy gel.

Decision rationale: There are no provisions for topical Biofreeze in the California Medical Treatment Utilization Schedule. Therefore the Official Disability Guidelines are referenced, which support the use of Biofreeze only in the context of acute low back pain. Specifically, the Official Disability Guidelines Low Back Chapter under the Biofreeze and Cryotherapy section state: "Recommended as an optional form of cryotherapy for acute pain. See also Cryotherapy, Cold/heat packs. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication. This randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group. (Zhang, 2008)" Given that this worker does not have documentation of acute low back pain but instead has had chronic pain, this request is not medically necessary.

Acupuncture 2X6 thoracic spine and right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions" and a reduction in the dependency on continued medical treatment". A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it is unclear what current concurrent rehabilitative exercises will be used alongside the requested acupuncture. Additionally, a summary of acupuncture to date for this chronic injury is not supplied. Since the independent medical review process cannot modify any requests, the currently requested acupuncture is not medically necessary.

Chiropractic Therapy 2X6 thoracic spine and right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 60-61.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic Page(s): 51.

Decision rationale: Regarding the request for chiropractic care, the Chronic Pain Medical Treatment Guidelines state on pages 58-60 the following regarding manual therapy & manipulation: "Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care: Not medically necessary. Recurrences/flare-ups: Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines: A. Time to produce effect: 4 to 6 treatments. B. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. C. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined." In the case of this injured worker, there is no comprehensive summary of chiropractic to date or functional benefit from prior chiropractic treatment. If this is an initial request, then it exceeds guideline recommendation which specify for an initial trial of up to 6 visits. Given these factors, this request is not medically necessary.