

Case Number:	CM15-0094184		
Date Assigned:	05/20/2015	Date of Injury:	12/16/2014
Decision Date:	07/02/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	05/15/2015

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

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 32-year-old female, with a reported date of injury of 12/16/2014. The diagnoses include cervical muscle spasm, cervical radiculopathy, cervical sprain/strain, lumbar disc protrusion, lumbar muscle spasm, lumbar radiculopathy, and lumbar sprain/strain. Treatments to date have included an MRI of the cervical spine on 02/18/2015 showed disc herniation at C4-5 and C5-6, chiropractic treatment, and an MRI of the lumbar spine on 02/18/2015 which showed disc desiccation, restricted range of motion, Schmorl's node throughout the lumbar spine, broad-based disc herniation, and spinal canal stenosis. The progress report dated 03/27/2015 indicates that the injured worker complained of intermittent, moderate, achy neck pain, and intermittent, moderate, achy, sharp low back pain with radiation to the left leg. The low back pain was rated 6 out of 10 with medication. The examination of the cervical spine showed decreased and painful range of motion, tenderness to palpation of the cervical paravertebral muscles, muscle spasm of the cervical paravertebral muscles, and pain with cervical compression. An examination of the lumbar spine showed decreased and painful range of motion, and tenderness to palpation of the left sacroiliac (SI) joint and lumbar paravertebral muscles. The treating physician requested acupuncture therapy to reduce pain and spasms, pain management consultation for evaluation of lumbar spine radiculopathy and the need for epidural injection, physical therapy for the cervical and lumbar spine to alleviate pain, and follow-up visit with specialist for medication consultation for pain medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture therapy 1 x per week x 6 weeks: Overturned

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Per the 03/27/15 progress report, the requesting physician states that the patient presents with intermittent, moderate, neck pain, and intermittent, moderate, lower back pain with radiation to the left leg. The low back pain was rated 6/10 with medication. The current request is for acupuncture therapy 1 x per week x 6 weeks per the 03/27/15 report. The patient is to return to modified duty 03/30/15 at the patient's request. 9792.24.1. Acupuncture Medical Treatment Guidelines. MTUS pg. 13 of 127 states: "(i) Time to produce functional improvement: 3 to 6 treatments (ii) Frequency: 1 to 3 times per week (iii) Optimum duration: 1 to 2 months (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)." The requesting physician states this request is to reduce pain and spasms. There is no evidence of prior acupuncture treatment. In this case, the MTUS guidelines allow up to 6 sessions over 1 to 2 months as an initial trial. Cervical and lumbar pain and spasm are well documented for this patient. The request IS medically necessary.

Pain management consult for evaluation of the lumbar spine radiculopathy and the need for epidural injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Pain, Office Visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7 page 127, consult.

Decision rationale: Per the 03/27/15 progress report, the requesting physician states that the patient presents with intermittent, moderate, neck pain, and intermittent, moderate, lower back pain with radiation to the left leg. The low back pain was rated 6/10 with medication. The current request is for pain management consult for evaluation of the lumbar spine radiculopathy and the need for epidural injection per the 03/27/15 report. The patient is to return to modified duty 03/30/15 at the patient's request. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7 page 127 state, "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification." The reports provided document symptoms of cervical and lumbar radiculopathy for this patient. The guidelines allow referral to other specialists when additional expertise may assist the physician

in providing an appropriate course of care. The request IS medically necessary.

Physical therapy 1 x per week x 6 weeks for the cervical and lumbar spine: 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: Per the 03/27/15 progress report, the requesting physician states that the patient presents with intermittent, moderate, neck pain, and intermittent, moderate, lower back pain with radiation to the left leg. The low back pain was rated 6/10 with medication. The current request is for physical therapy 1 x per week x 6 weeks for the cervical and lumbar spine per the 03/27/15 and 02/17/15 reports. The 03/27/15 RFA included is illegible. The patient is to return to modified duty 03/30/15 at the patient's request. MTUS pages 98, 99 states that for Myalgia and myositis 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis and radiculitis 8-10 visits are recommended. There is no evidence the patient is within a post-surgical treatment period. The requesting physician does not discuss prior physical therapy for this patient. Soap notes provided for review show that the patient received at least 15 visits for treatment of the cervical and lumbar spine from 01/26/15 to 03/25/15. It is unclear from the reports provided if the requested 6 sessions are part of these 15 visits or are requested in addition to the already received visits. No evidence of objective functional improvement from physical therapy treatment is provided. The 03/27/15 note states the patient feels that pain decreases after treatment. However, pain is rated 7/10 on 01/26/15 and 6-7/10 on 03/25/15. There is no discussion of a flare-up in pain or new injury or discussion of transition to HEP. Furthermore, the 15 visits received exceed what is allowed by the MTUS guidelines. The request IS NOT medically necessary.

Follow-up with MD for medication consult for pain medication: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Office Visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7 page 127, consult.

Decision rationale: Per the 03/27/15 progress report, the requesting physician states that the patient presents with intermittent, moderate, neck pain, and intermittent, moderate, lower back pain with radiation to the left leg. The low back pain was rated 6/10 with medication. The current request is for follow-up with MD for medication consult for pain medication per the 03/27/15 report. The patient is to return to modified duty 03/30/15 at the patient's request. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7 page 127 state, "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex,

when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. An independent medical assessment also may be useful in avoiding potential conflict(s) of interest when analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification." The current reports provided for review do not state what medications are prescribed for this patient. The treating physician does assess pain with medications on 03/27/15. However, this patient's continuing pain is well documented and guidelines allow referral to other specialists when the course of care may benefit from additional expertise. The request IS medically necessary.