

Case Number:	CM14-0135031		
Date Assigned:	08/29/2014	Date of Injury:	10/27/2011
Decision Date:	12/24/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/21/2014

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. The expert reviewer is Board Certified in Pain Management and Rehabilitation, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 33 year old female with date of injury 10/27/11 stemming from a car accident. The treating physician report dated 10/15/14 indicates that the patient presents with pain affecting neck rated 4/10, bilaterel shoulder rated 6/10, lower back rated 9/10, numbness/tingling in legs accompanied by bilateral intermittent pain rated 2-6/10 respectively. Cervical and lumbar spine examinations revealed mild tenderness on palpation. Prior treatment history includes 8 chiropractic treatments 7/11/14 to 8/14/14, acupuncture 2 X per week for 3 weeks noted in progress report dated 6/25/14, 2 lumbar epidural steroid injections 3/17/14, 4/25/14, 8/8/14, TENS unit 3+ hours per day for an undocumented time period, trigger point injection in shoulder 10/2/14, non-documented out-of-pocket massage therapy and prescription medications including Norco, Percocet, Soma, Flexeril, and Gabapentin. The patient continues to take Neurontin, Skelaxin and Percocet as needed. Lumbar and cervical CT scan taken on 2/26/14 revealed interim fusion and moderate foraminal stenosis. The current diagnoses are: 1. Cervical and lumbar pain 2. Radiculopathy 3. HNP 4. Sprain 5. Sciatica. The utilization review report dated 7/28/14 denied the request for massage therapy 2 times per week for 4 weeks for the lumbar and cervical spine based on limited documentation of previous massage therapy visits and their lasting and/or objective functional gains obtained from the treatment. The UR physician denied the request for 2 X1 chiropractic treatment due to a lack of documented "functional improvement." The UR physician denied the request for 2 X 1 acupuncture due to a lack of documented pain reduction and "functional improvement."

IMR ISSUES, DECISIONS AND RATIONALES

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

Massage Therapy 2 x 4 Lumbar and Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

Decision rationale: The patient presents with chronic neck, back and leg pain approximately 36 months post injury and approximately 23 months post surgery of L5-S1 anterior lumbar interbody fusion and Pro-Disk artificial replacement at the L4-5 level. The current request is for massage therapy 2 times per week for 4 weeks for the lumbar and cervical spine. Physician report dated 10/15/14 states "Even though her continued use of the above mentioned conservative treatment has helped with her pain, she also states the she cannot go too long without eventually aggravating her pain." The patient has not shown any documented objective functional gains from prior therapy sessions. The current request is for massage therapy 2 times per week for 4 weeks for the lumbar and cervical spine. The MTUS guidelines state that massage therapy is recommended as an option with limitation to 4-6 visits and is supported for patients post operatively. There is no medical documentation of any rationale as to why the patient requires care above and beyond the MTUS recommendations and treating physician did not document any functional improvement. The request for Massage Therapy 2 x 4 Lumbar and Cervical Spine is not medically necessary.

Chiropractor 2 X 1 Month: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: The patient presents with chronic neck, back and leg pain approximately 36 months post injury and approximately 23 months post surgery of L5-S1 anterior lumbar interbody fusion and Pro-Disk artificial replacement at the L4-5 level. The current request is for 2 X 1 Month chiropractor visit. Documentation was provided for 8 chiropractic treatments from 7/11/14 to 8/4/14. The primary treating physician performed a range of motion exam on 7/14/14, 3 days after initial chiropractic visit and patient was well below the normal average. Cervical flexion 30 degrees, extension 20 degrees, right and left lateral bending 20 degrees, right and left rotation 40 degrees. The treating physician performed a range of motion exam on patient 10/15/14 9 weeks after last chiropractic visit on 8/4/14. Cervical flexion 50 degrees, extension 40 degrees, right and left bending 40 degrees, right and left rotation 80 degrees. In this case the treating physician has showed functional improvement with prior chiropractic care and currently presents with a flare up and need for 2 chiropractic treatments. The request for Chiropractor Sessions 2 X 1 Month is not medically necessary.

Additional Acupuncture 2 X 1 Month: Overturned

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The patient presents with chronic neck, back and leg pain approximately 36 months post injury and approximately 23 months post surgery of L5-S1 anterior lumbar interbody fusion and Pro-Disk artificial replacement at the L4-5 level. The current request is for 2 X 1 month acupuncture visit. The only documentation of a previous acupuncture visit was a progress report dated 6/25/14. The report stated that the patient received 2 treatments per week for 3 weeks. In the progress report measurable outcomes mentioned were "reduced pain, increased range of motion, increased ability to perform ADL, reduced pain behaviors, reduced pain medications, improved sleep." In reviewing the acupuncture treatment guidelines it states that acupuncture treatments may be extended if functional improvement is documented. In this case the treating physician has documented functional improvement with prior treatment. The request for Additional Acupuncture 2 X 1 Month is not medically necessary.