

Case Number:	CM13-0026047		
Date Assigned:	11/22/2013	Date of Injury:	12/12/2006
Decision Date:	03/18/2014	UR Denial Date:	09/10/2013
Priority:	Standard	Application Received:	09/19/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Chiropractor and is licensed to practice in Texas. 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 physician 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 57-year-old female who reported an injury on 12/12/2006. The patient is diagnosed with paraparesis, lumbar spinal stenosis, chronic low back pain with radiation to the left lower extremity, left L3-4 lumbar radiculopathy, bilateral L5 radiculopathy, neuropathic pain of bilateral lower extremities, possible arachnoiditis, neurogenic bowel, occasional urinary incontinence, gait and balance dysfunction, impaired activities of daily living, impaired mobility skills, anxiety, and pain in bilateral shoulder blades. The patient was seen by [REDACTED] on 09/03/2013. The patient was actively participating in physical therapy with electric acupuncture. The patient reported ongoing low back pain with radiation to the left lower extremity. Physical examination revealed markedly diminished sensation at the lateral aspect of bilateral lower extremities, tenderness over the scapular muscles on bilateral shoulders, the lumbosacral areas, and paraparesis on the left side. Treatment recommendations included continuation of physical therapy with aquatic therapy and electric acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

electrical acupuncture treatments twice a week for eight weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California Medical Treatment Utilization Section (MTUS) Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The time to produce functional improvement includes 3 to 6 treatments with a frequency of 1 to 3 times per week. An optimum duration includes 1 to 2 months. Acupuncture treatment may be extended if functional improvement is documented. As per the clinical notes submitted, the patient has been actively participating in electrical acupuncture. The patient continues to report ongoing low back pain with radiation to the left lower extremity, despite ongoing treatment. Documentation of significant functional improvement was not provided. Therefore, continuation cannot be determined as medically appropriate. As such, the request is noncertified.

physical therapy, including pool therapy, three hours per session, three days a week for eight weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Duration Guidelines, Treatment in Workers Compensation, 2013

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22,98-99.

Decision rationale: California Medical Treatment Utilization Section (MTUS) Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. Aquatic therapy is recommended as an optional form of exercise therapy. Aquatic therapy can minimize the effects of gravity, so it is specifically recommended where reduced weightbearing is desirable. As per the clinical notes submitted, the patient has continuously participated in physical therapy and aquatic therapy. Despite the ongoing treatment, the patient continues to report lower back pain with radiation to the left lower extremity. Documentation of a significant functional improvement was not provided. Additionally, there is no indication that the patient requires reduced weight bearing as opposed to land-based physical therapy. Based on the clinical information received, the request is noncertified.