

Case Number:	CM14-0003411		
Date Assigned:	01/31/2014	Date of Injury:	05/02/2013
Decision Date:	06/23/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/08/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 22 year old female with a reported date of injury on 05/03/2013. The mechanism of injury occurred with the worker slipped and landed on the lumbar spine. The progress noted dated 12/17/2013 reported a positive straight leg raise and a left wrist range of motion was extension 60/60, flexion 60/60, radial deviation 20/20, and ulnar deviation 30/30. The progress noted also reported the range of motion to the left/right knee were decreased and painful, and the left ankle ranges of motion was painful. The lumbar spine ranges of motion was decreased and painful at extension 10/25 and flexion 15/60. The diagnoses listed were lumbar muscle spasms, lumbar sprain/strain, lumbosacral sprain, strain, left wrist sprain/strain, left knee sprain/strain, right knee sprain/strain, left ankle deltoid sprain/strain, right ankle sprain/strain, anxiety, depression, and nervousness. The request of authorization form dated 01/21/2014 was form chiropractic treatment 2x4 due to spasm of muscle, lumbago, thoracic/lumbosacral radiculitis, lumbar sprain/strain, lumbosacral sprain/strain, pain in joint of forearm, wrist strain and ankle sprain/strain.f forearm, wrist strain and ankle sprain/strain.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE 1-2 X 4 WKS L/S, L WRIST, KNEES / ANKLES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACUPUNCTURE MEDICAL TREATMENT GUIDELINES

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture 1-2 x4 weeks L/S, left wrist, and knees and ankles is non-certified.. The injured worker has received physical therapy in the past. The Acupuncture guidelines state it is used as an option when pain medication is refused or not tolerated, it may be used as an adjunct to physical rehabilitation and /or surgical intervention to hasten functional recovery. The recommended frequency and duration of acupuncture is 3 to 6 treatment 1 to 3 times per week. There is a lack of documentation regarding use of medication other than Naproxen was ineffective, the injured worker underwent physical therapy but no functional improvements were documented. There is a lack of documentation regarding pain medications and if there will be an adjunct to the acupuncture. Therefore, the request is not medically necessary or appropriate.

CHIRO 2-3 X 6 WEEKS L/S L WRIST, KNEES / ANKLES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, HAND AND WRIST DISORDERS

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

Decision rationale: The request for chiropractic therapy 2-3 x6 weeks to the L/S, left wrist, knees, and ankles is non-certified. The injured worker has undergone physical therapy. The California Chronic Pain Medical Treatment guidelines recommend chiropractic therapy for chronic pain if cause by musculoskeletal conditions. The guidelines recommend chiropractic therapy for the low back as a trial of 6 visits over 2 weeks. The guidelines however, do not recommend chiropractic therapy for the wrist, knee and ankles. Therefore, the request is not medically necessary.

SLEEP STUDY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Polysomnography

Decision rationale: The request for a sleep study is non-certified. The injured worker does not have a diagnosis of insomnia. The Official Disability Guidelines recommend a sleep study after at least six months of an insomnia complaint, unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. The guidelines do not recommend for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. The guidelines criteria are recommended for

the combination indications such as excessive daytime somnolence, cataplexy, morning headache (other causes have been rule out), intellectual deterioration, personality change, sleep-related breathing disorder or periodic limb movement disorder is suspected, and insomnia complaint for at least six months. There is a lack of documentation regarding insomnia or sleep-promoting medications attempted. Therefore, the request is not medically necessary.