

Case Number:	CM14-0006679		
Date Assigned:	02/07/2014	Date of Injury:	10/10/2013
Decision Date:	06/23/2014	UR Denial Date:	01/08/2014
Priority:	Standard	Application Received:	01/17/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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 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 29-year-old male who sustained an injury to his low back on 10/10/13. The mechanism of injury was not documented. The injured worker also complained of continuous constant severe pain (9/10) to the mid back region when breathing inward. The injured worker complained of low back pain at 9/10 on the Visual Analogue Scale (VAS) that radiates down the bilateral lower extremities. Range of motion in the lumbar spine flexion is 30° with pain, extension 30° with pain, right rotation 30°, right left rotation 30°, right lateral bending 30°, left lateral bending 15° with pain. There was moderate to severe palpable tenderness to the lumbar spine, moderate tenderness was elicited to the thoracic spine at T3 through T10 and L1 through L5, motor strength 5/5 bilaterally. MRI of the lumbar spine dated 01/05/14 revealed at L4-5, 4mm broad-based posterior disc protrusion which displaces the posterior longitudinal ligament posteriorly and results in mild to moderate central canal stenosis and no neuroforaminal narrowing bilaterally. The injured worker was diagnosed with lumbar disc herniation and lumbar radiculitis. This request is for acupuncture and heat/cold compression therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE 2X4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture two times a week for four weeks is not medically necessary. The previous request was denied on the basis that that the requested eight visits exceeds acupuncture guidelines. Therefore, certification of the requested acupuncture two times week times four weeks was modified for an initial trial of six visits. There was no additional significant objective clinical information provided that would support the need to exceed the California Medical Treatment Utilization Schedule recommendations in frequency or duration of acupuncture therapy visits. Given the clinical documentation submitted for review, medical necessity of the request for acupuncture two times a week times four weeks has not been established.

HOT/COLD COMPRESSION UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medline, Cinahl and the Cochrane Library.

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, Cold/Heat Packs.

Decision rationale: The request for hot/cold compression unit is not medically necessary. The previous request was denied on the basis that guidelines do not consistently support use of hot/cold therapy contrast systems in the management of the cited injury/condition; therefore certification of the requested hot/cold compression unit was not recommended. There was no additional significant clinical information provided that would support exceeding the California Medical Treatment Utilization Schedule recommendations. Given the clinical documentation submitted for review, medical necessity of the request for hot/cold compression unit has not been established.