MAXIMUS Federal Services

Case Number:	CM14-0109973		
Date Assigned:	09/16/2014	Date of Injury:	09/02/2013
Decision Date:	10/24/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/15/2014

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:

This injured worker is a 51 year old female with a reported date of injury of September 02, 2013. Mechanism of injury noted as a slip and fall on a wet floor, while performing the regular duties of her occupation as a waitress/cashier, injuring her head, neck and right shoulder. It is reported that she also hit her head on a table as she fell. Diagnosis includes concussion with loss of consciousness of 30 minutes or less and sprain of neck. Pain Management office visit note dated June 12, 2014, indicates injured worker had complaints of moderate pain that is constant in the neck with radiation to the upper mid back and occipital headaches bilaterally. The pain is aggravated by pushing, pulling, repetitive head motions, and flexion, extension and rotation activities. She also complains of constant pain in the shoulder on the right side that radiates to the wrist, hand and fingers on the right side that is accompanied by numbness and tingling in the arm. The shoulder pain is aggravated by the arm function, hand function and activity. The injured worker reports moderate to severe difficulty sleeping. Past treatment history indicated as medication that provided no help, acupuncture that provided no help and chiropractic treatments that had provided limited benefit. The work status, as of this office visit, was reported as temporary partially disabled with limitations of no pushing, pulling or lifting more than five pounds. No indication of requested treatments noted in documentation provided. Prior utilization review denied request for myofascial release (8 Sessions), infrared heat (8 Sessions) and electro acupuncture (8 Sessions) on June 30, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Myofascial Release (8 Sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

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

Decision rationale: CA MTUS recommends manual therapy and manipulation for chronic pain caused by musculoskeletal conditions in order to achieve positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The injured worker reported limited benefit from previous chiropractic treatment. There is no indication of the number of visits of chiropractic treatment completed to date. Based on the clinical information provided, noting the lack of efficacy of treatment to date, the request for 8 Myofascial Release (8 Sessions) is not medically necessary.

8 Infrared Heat (8 Sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288-299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Infrared therapy (IR)

Decision rationale: ACOEM guidelines reflect that the use of thermal modalities such as ice and/or heat may help in relieving discomfort. At home local applications of heat or cold are appropriate. Official Disability Guidelines (ODG) reflects that infrared therapy is not recommended over other heat therapies. If deep heating is desirable, a trial of IR may be indicated for acute low back pain but only if used as an adjunct to an evidence-based exercise program. There is no indication that the injured worker is participating in or compliant with an exercise program. Based on the clinical information provided, the request for 8 Infrared Heat (8 Sessions) is not medically necessary.

8 Electro Acupuncture (8 Sessions): Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS guidelines apply to acupuncture or acupuncture with electrical stimulation. Acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Time to produce functional improvement is 3 to 6 treatments. If functional

improvement is documented treatment may be extended. The injured worker previously was approved for 12 sessions of acupuncture, but she did not complete treatment as it was no help. As such, this request is not medically necessary.