

Case Number:	CM14-0013753		
Date Assigned:	02/26/2014	Date of Injury:	03/06/2013
Decision Date:	06/26/2014	UR Denial Date:	01/04/2014
Priority:	Standard	Application Received:	02/03/2014

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 Internal Medicine & Emergency Medicine and is licensed to practice in Florida. 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 patient is a 37 year-old with a date of injury of 03/06/13. A progress report associated with the request for services, dated 12/27/13, identified subjective complaints of pain in the low back, head, neck, shoulders, hands and fingers. Objective findings included tenderness to palpation in all the affected areas. There was decreased sensation in the cervical and lumbar dermatomes. Diagnoses included shoulder, arm, thoracic, and lumbar strain; cervical disc disease; and headache. Treatment has included exercise and 6 sessions of acupuncture resulting in what was described as limited improvement. She is on NSAIDs and oral analgesics. A Utilization Review determination was rendered on 01/03/14 recommending non-certification of "six (6) electro acupuncture visits with or without stimulation to the lumbar spine; one transcutaneous electrical unit (TENS); one pain management consultation for evaluation, treatment recommendations and possible injections; and one return visit in 5-6 weeks for follow-up for ongoing treatment and assess status".

IMR ISSUES, DECISIONS AND RATIONALES

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

SIX (6) ELECTRO ACUPUNCTURE VISITS WITH OR WITHOUT STIMULATION TO THE LUMBAR SPINE: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACUPUNCTURE MEDICAL TREATMENT GUIDELINES.

Decision rationale: The MTUS Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, or as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It further states that acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range-of-motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The frequency and duration of acupuncture is listed as: Time to produce functional improvement: 3 to 6 treatments; Frequency: 1 to 3 times per week; and Optimum duration: 1 to 2 months. It is noted that acupuncture treatments may be extended if functional improvement is documented. In this case, the optimum duration of acupuncture has been exceeded. The patient has had six previous sessions and the medical records do not document adequate functional improvement to extend the treatments. Therefore, there is no documented medical necessity for additional acupuncture as requested. The request for six electro acupuncture visits with or without stimulation to the lumbar spine is not medically necessary and appropriate.

ONE TRANSCUTANEOUS ELECTRICAL UNIT (TENS): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 12- LOW BACK COMPLAINTS, 303

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TENS , 114-117

Decision rationale: The California MTUS states that TENS is not recommended for the low back. For other conditions, a one month trial is considered appropriate if used as an adjunct to an evidence-based program of functional restoration. The recommended types of pain include; neuropathic pain; CRPS I and II; phantom limb pain; spasticity; and multiple sclerosis. For chronic intractable pain from these conditions, the following criteria must be met: Documentation of pain for at least three months duration; evidence that other appropriate pain modalities have been tried (including medication) and failed; a one-month trial period of the tens unit should be documented with documentation of how often it was used, as well as the outcomes in terms of pain relief and function; other ongoing pain treatment should also be documented during the trial period including medication usage; a treatment plan including the specific short- and long-term goals of treatment with the tens unit should be submitted. In this case, the TENS unit is being requested for at least one type of pain not specified as indicated for treatment. TENS is not recommended for the low back. Also, the multiple criteria noted above (documentation of duration of pain, trial plan, and goal plan) have not been met. Furthermore, a one-month trial should be attempted, therefore, there is no documented medical necessity for a

TENS unit as requested. The request request for a Transcutaneous Electrical Unit (TENS) is not medically necessary and appropriate.

ONE PAIN MANAGEMENT CONSULTATION FOR EVALUATION, TREATMENT RECOMMENDATIONS AND POSSIBLE INJECTIONS: 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 MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PAIN INTERVENTIONS AND TREATMENT, 11

Decision rationale: The Official Disability Guidelines (ODG) state that: "The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment." ODG further notes that patient conditions are extremely varied and that a set number of office visits per condition cannot be reasonably established. The MTUS guidelines state that there is no set visit frequency. It should be adjusted to the patient's need for evaluation of adverse effects, pain status, and appropriate use of medication, with recommended duration between visits from 1 to 6 months. In this case the claimant continues to have pain requiring chronic opioid therapy and, as noted above, there is documented medical necessity for a consultation. However, the request is also for "possible injections" without specification as to type, number, or location, the necessity of the request is not established. Therefore, the request for one pain management consultation for evaluation, treatment recommendations and possible injections are not medically necessary and appropriate.

ONE RETURN VISIT IN 5-6 WEEKS FOR FOLLOW-UP FOR ONGOING TREATMENT AND ASSESS STATUS: 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 MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PAIN INTERVENTIONS AND TREATMENT, 11

Decision rationale: The Official Disability Guidelines (ODG) state that: "The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment." They further note that patient conditions are extremely varied and that a set number of office visits per condition cannot be reasonably established. The MTUS guidelines state that there is no set visit frequency. It should be adjusted to the patient's need for evaluation of adverse effects, pain status, and appropriate use of medication, with recommended duration between visits from 1 to 6 months. The Claims Administrator partially certified 1 return visit in 5-6 weeks for follow up to assess status, but not ongoing treatment, as that could only be determined at the time

of the assessment. The record does not document the specific follow-up treatment requested, therefore the medical necessity for the total request has not been established. The request for one return visit in 5-6 weeks for the follow up for ongoing treatment and assess status are not medically necessary and appropriate.