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| Case Number: | CM14-0121912 | | |
| Date Assigned: | 08/06/2014 | Date of Injury: | 07/29/2006 |
| Decision Date: | 10/01/2014 | UR Denial Date: | 07/11/2014 |
| Priority: | Standard | Application Received: | 08/01/2014 |

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 Family Practice and is licensed to practice in Texas and Mississippi. 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 67-year-old male who reported an injury on 07/29/2006, reportedly while working his usual customary duties he was lifting a sign with 2 co-workers that weighed approximately 400 pounds. He stated that he accidentally stepped on a pipe and he automatically felt a sharp pain in his lower back, right groin, and right leg. The injured worker's prior treatment included medications, trigger point injections, MRI studies, physical therapy, chiropractic treatment, and acupuncture sessions. The injured worker was evaluated on 06/06/2014 and it was documented the injured worker complained of aching pain in the low back radiating to the right leg. He takes pain medication to help with pain. Pain was rated at 4/10 on the pain scale. Examination revealed tenderness to palpation of the spinous process at L4-5. Sit root test and straight leg raise was positive on the right at 80 degrees and negative on the left. There was mild decrease in sensory function to pinwheel at L2 dermatome. Deep tendon reflexes at patellar and Achilles were normal. Range of motion was decreased by 5 degrees in all planes. Diagnoses included lumbar spine discopathy and right lower extremity radiculitis. The Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2 x 6 weeks: 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 2 X 6 is not medically necessary. Per the Acupuncture Medical Treatment Guidelines, it is stated Acupuncture Medical Treatment Guidelines state that "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. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. 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 guidelines state that the frequency and duration of acupuncture with electrical stimulation may be performed to produce functional improvement for up to 3 to 6 treatments no more than 1 to 3 times per week with a duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. According to the records submitted indicated the injured worker has received acupuncture sessions and physical therapy sessions. However, the provider failed to indicate outcome measures. The request failed to indicate location where acupuncture treatment is required for the injured worker. Given the above, the request for acupuncture is not medically necessary.

Multi-Stim unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy. Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 114-116.

Decision rationale: The requested is not medically necessary. Chronic Pain Medical Treatment Guidelines does not recommend a tens unit as a primary treatment modality, but a one-month home-based Tens trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration and other ongoing pain treatment including medication usage. It also states that the tens unit is recommended for neuropathic pain including diabetic neuropathy and post-herpetic neuralgia. The guidelines recommends as a treatment option for acute post-operative pain in the first thirty days post-surgery. The provider failed to indicate long- term functional restoration goals for the injured worker. In addition, the request failed to indicate frequency and location where the Multi Stim Unit Plus should be used on the injured worker. Given the above, the request for Multi Stim Unit plus Supplies is not medically necessary.

Sleep studies: 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 (Chronic) Polysomnography.

Decision rationale: The requested is not medically necessary. Per Official Disability Guidelines (ODG) state that sleep studies are recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Home portable monitor testing may be an option. The provider failed to indicate the injured worker suffering from insomnia. As such, the request for sleep studies is not medically necessary.

Aquatherapy (lumbar): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy & Physical Medicine Page(s): 22& 99.

Decision rationale: The request for aqua therapy for lumbar is not medically necessary. The CA MTUS Chronic Pain Medical Treatment Guidelines recommend aqua therapy as an optional form of exercise therapy, where available as alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity so it is especially recommended when reduced weight bearing is desirable, for example, extreme obesity. Physical medicine guidelines recommend a total of 9-10 visits over 8 weeks for myalgia and myositis, and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. It was noted that the injured worker had 6 weeks of prior sessions of physical therapy and aquatic therapy sessions; however, there was lack of documentation provided on the outcome measure and functional improvement. There was lack of documentation on the injured worker's outcome of conservative care such as, prior physical therapy and home exercise regimen. Furthermore, the documentation lacked the injured worker long-term goal for functional improvement. The request submitted failed to indicate frequency and duration. As such, the request is not medically necessary.