

Case Number:	CM14-0027009		
Date Assigned:	06/13/2014	Date of Injury:	05/09/2012
Decision Date:	07/16/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	03/04/2014

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 Orthopedic Surgery and is licensed to practice in California. 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 32 year-old male injured on 5/9/2012. The mechanism of injury is noted as a box of plates fell on his right foot/ankle. The claimant underwent an ORIF for a distal tibia/fibula fracture in February 2008. The most recent progress note dated 1/13/2014, indicates that there are ongoing complaints of low back pain, right shoulder pain and right ankle pain. Physical examination demonstrated slow guarded gait with SPC; lumbar spine range of motion is decreased and painful: extension 10/25, flexion 20/60, left/right lateral bending 15/25; tenderness and spasm in to paravertebral muscles; Kemp's positive bilaterally; right shoulder range of motion decreased and painful: abduction 40/180, adduction 15/40, extension 15/50, external rotation 80/90, flexion 30/180, internal rotation 45/80; tenderness to the acromioclavicular joint and entire shoulder; supraspinatus press is positive; right ankle range of motion decreased and painful with swelling and tenderness; inversion/eversion test causes pain. EMG of the lower extremities dated 11/12/2012 revealed a right S1 radiculopathy. MRI of the lumbar spine dated 11/12/2012 revealed a disc protrusion and degenerative disc disease at L1/2 with an anterior wedge compression fracture of L1. CT scan of the right foot dated 9/24/2012 revealed mild hypertrophic changes at the first metatarsophalangeal joint with mild hallux valgus deformity status post ORIF of distal tibia/tibia. Previous treatment includes physical therapy, chiropractic treatment, epidural steroid injections, facet injections, ankle stellate ganglion blocks and medications. A request had been made for electro-acupuncture 2 times a week for 4 weeks to low back and right leg/ankle (Quantity 8.00); infrared therapy (Quantity 8.00); and lumbar spinal decompression therapy (Quantity 12.00) on 2/5/2014. Electro-acupuncture was partially certified for 6 sessions; infrared therapy and lumbar spinal decompression therapy were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTRO-ACUPUNTURE 2 TIMES A WEEK FOR 4 WEEKS TO THE LOW BACK AND RIGH LEG/ANKLE QTY 8.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Page(s): 13.

Decision rationale: The California Medical Treatment Utilization Schedule support acupuncture as an option when pain medication is reduced or not tolerated or as an adjunct to physical rehabilitation to hasten functional recovery. A request has been made for 8 sessions; however, California guidelines only support a maximum of 6 sessions over 2 months. As such, this request is not considered medically necessary.

INFARED THERAPY QTY: 8.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: The American College of Occupational and Environmental Medicine (ACOEM) guidelines do not recommend the use of infrared therapy for treatment of acromioclavicular sprains or dislocations and infrared therapy is not recommended the treatment of neuropathic pain or for trigger points/myofascial pain. The guidelines do not support this request; therefore, it is not considered medically necessary.

LUMBAR SPINAL DECOMPRESSION THERAPY QTY:12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: The American College of Occupational and Environmental Medicine (ACOEM) guidelines do not support decompression through traction and spinal decompression devices for the treatment of acute, sub-acute or chronic low back pain. As such, this request is not considered medically necessary.