

Case Number:	CM14-0039146		
Date Assigned:	06/27/2014	Date of Injury:	03/05/2013
Decision Date:	08/20/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	04/03/2014

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 Physical Medicine and Rehabilitation 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:

According to the records made available for review, this is a 30-year-old female with a 3/5/13 date of injury. At the time (2/12/14) of request for authorization for additional acupuncture 2 times a week for 3 weeks to the right wrist, DME: Infra Lamp, and Kinesio tape for the right wrist, there is documentation of subjective (ongoing neck pain, mid back pain, bilateral wrist pain, and bilateral shoulder pain) and objective (tenderness to palpation over bilateral wrists with decreased range of motion, tenderness to palpation over the shoulders with positive impingement sign and decreased range of motion, tenderness to palpation over the cervical and thoracic spines with decreased range of motion) findings, current diagnoses (cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, bilateral shoulder sprain/strain, and bilateral wrist sprain/strain), and treatment to date (at least 18 acupuncture sessions with decreased pain levels, decreased medication use, and improved functioning). Regarding DME: Infra Lamp, there is no documentation that the request is primarily and customarily used to serve a medical purpose and represents medical treatment that should be reviewed for medical necessity. Regarding Kinesio tape for the right wrist, there is no documentation of the need for providing support and stability in movement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Acupuncture 2 times a week for 3 weeks to the Right wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Acupuncture Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: MTUS Acupuncture Medical Treatment Guidelines identifies that acupuncture may be 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, 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. In addition, MTUS Acupuncture Medical Treatment Guidelines allow the use of acupuncture for musculoskeletal conditions for a frequency and duration of treatment as follows: Time to produce functional improvement of 3-6 treatments, frequency of 1-3 times per week, and duration of 1-2 months. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, bilateral shoulder sprain/strain, and bilateral wrist sprain/strain. In addition, there is documentation of previous acupuncture therapy. Furthermore, given documentation of decreased pain levels, decreased medication use, and improved functioning with previous acupuncture therapy, there is documentation of functional benefit or improvement as an increase in activity tolerance and a reduction in the use of medications as a result of acupuncture provided to date. However, given documentation of 18 acupuncture sessions completed to date, which is the limit of guidelines, there is no documentation of exceptional factors to justify exceeding guidelines. Therefore, based on guidelines and a review of the evidence, the request for additional acupuncture 2 times a week for 3 weeks to the right wrist is not medically necessary.

Infra Lamp: 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) Knee, Durable medical equipment (DME) and on Other Medical Treatment Guideline or Medical Evidence:<http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>.

Decision rationale: MTUS does not address this issue. ODG identifies documentation that the requested durable medical equipment (DME) can withstand repeated use (i.e. could normally be rented, and used by successive patients); and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, as criteria necessary to support the medical necessity of durable medical equipment. The Medical Treatment Guideline identifies documentation that the request represents medical treatment in

order to be reviewed for medical necessity, as criteria necessary to support the medical necessity of the requested DME: Infra Lamp. A search of online resources failed to provide any articles/studies addressing criteria for the medical necessity for the requested Infra Lamp. Within the medical information available for review, there is documentation of diagnoses of cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, bilateral shoulder sprain/strain, and bilateral wrist sprain/strain. However, there is no documentation that the request is primarily and customarily used to serve a medical purpose and represents medical treatment that should be reviewed for medical necessity. Therefore, based on guidelines and a review of the evidence, the request for an Infra Lamp is not medically necessary.

Kinesio tape for the Right wrist: 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 Other Medical Treatment Guideline or Medical Evidence: (<http://www.kinesiotaping.com/about/kinesio-taping-method>); (<http://www.expertconsultbook.com/expertconsult/ob/book.do?method=display&type=bookPage&decorator=none&eid=4-u1.0-B978-0-323-05602-1..00119-7--s0100&isbn=978-0-323-05602-1>).

Decision rationale: MTUS and ODG do not address this issue. The cited Medical Treatment Guideline identifies that Kinesio taping is a definitive rehabilitative taping technique that is designed to facilitate the body's natural healing process while providing support and stability to muscles and joints without restricting the body's range of motion as well as providing extended soft tissue manipulation to prolong the benefits of manual therapy administered within the clinical setting. In addition, the Medical Treatment Guideline identifies documentation of pain or abnormal feeling in skin and muscles, and the need for providing support and stability in movement, as criteria necessary to support the medical necessity of Kinesio tape. Within the medical information available for review, there is documentation of diagnoses of cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, bilateral shoulder sprain/strain, and bilateral wrist sprain/strain. In addition, there is documentation of right wrist pain. However, despite documentation of subjective (ongoing bilateral wrist pain) and objective (tenderness to palpation over bilateral wrists with decreased range of motion) findings, there is no documentation of the need for providing support and stability in movement. Therefore, based on guidelines and a review of the evidence, the request for Kinesio tape for the right wrist is not medically necessary.