

Case Number:	CM15-0008318		
Date Assigned:	01/23/2015	Date of Injury:	11/10/2012
Decision Date:	03/13/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	01/14/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 52 year old male patient, who sustained an industrial injury on 11/10/2012. A pain management follow up visit dated 12/01/2014 reported subjective complaint of lower back pain; along with rib and abdominal pain. He rated the pain an 8 out of 10 in intensity and characterized it as a burning, throbbing sensation that radiates to the left thigh. In addition, he reported the pain medicine as offering effective relief. He is prescribed the following; Protonix, Tramadol, Lidocaine and Gabapentin. Physical examination found the lumbar range of motion restricted with flexion limited to 30 degrees by pain and extension at 10 degrees also limited by pain. There was tenderness to palpation noted at L1, L2, L3, L4 and L5. Straight leg raise found positive bilaterally at 60 degrees. Her motor range of motion noted limited by pain and sensory examination found light touch sensation decreased over L4, L5 and S1 dermatomes on the right side. She is diagnosed with chest pain not specified, chronic pain syndrome and abdominal pain site not specified. The plan of care described the patient's medication being denied over the past month resulting in increased pain and decreased activity. The patient is still awaiting further diagnostics and surgical evaluation. On 12/16/2014 Utilization Review non-certified a request for 8 acupuncture session, 1 psychological session, 1 lumbar brace and 1 interferential unit, noting Official Disability Guidelines Acupuncture Medical Treatment Guidelines, CA MTUS Psychological evaluation, ACOEM Chapter 12 Low Back were cited. The injured worker submitted an independent medical review of services.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Acupuncture sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Acupuncture Guidelines

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: It is not clear if the patient has participated in previous acupuncture. Current clinical exam show no specific physical impairments or clear dermatomal/ myotomal neurological deficits to support for treatment with acupuncture to the cervical and thoracic spine. The patient has been certified physical therapy without documented functional improvement. There are no clear specific documented goals or objective measures to identify for improvement with a functional restoration approach for this injury with ongoing unchanged chronic pain complaints. MTUS, Acupuncture Guidelines recommend initial trial of conjunctive acupuncture visit of 3 to 6 treatment with further consideration upon evidence of objective functional improvement. Submitted reports have not demonstrated the medical indication to support this request or specific conjunctive therapy towards a functional restoration approach for acupuncture visits, beyond guidelines criteria for initial trial. The 8 Acupuncture sessions is not medically necessary and appropriate.

1 Psychological evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): chapter 15, "Stress-related Conditions", page 398 > Chapter 7- Independent Medical Examinations and Consultations, page 127.

Decision rationale: Guidelines states that it recognizes that the primary care physician and other non-psychological specialists commonly deal with and try to treat psychiatric conditions. It is recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist; however, this has not been demonstrated here. The 1 Psychological evaluation is not medically necessary and appropriate.

1 Brace for lumbar support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 30.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Low Back Chapter, page 301.

Decision rationale: There is no indication of instability, compression fracture, or spondylolisthesis precautions to warrant a lumbar support beyond the acute injury phase. Reports have not adequately demonstrated the medical indication for the custom back brace. Based on the information provided and the peer-reviewed, nationally recognized guidelines, the request for an LSO cannot be medically recommended. CA MTUS states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This claimant is well beyond the acute phase for this chronic injury. In addition, ODG states that lumbar supports are not recommended for prevention and is under study for the treatment of nonspecific LBP and only recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, post-operative treatment, not demonstrated here. The 1 Brace for lumbar support is not medically necessary and appropriate.

1 Interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, pages 115-118.

Decision rationale: The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved work status derived from any transcutaneous electrotherapy to warrant a purchase of an interferential unit for home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process with return to work and exercises not demonstrated here. The 1 Interferential unit is not medically necessary and appropriate.