MAXIMUS Federal Services

Case Number:	CM15-0023950		
Date Assigned:	02/13/2015	Date of Injury:	04/21/2008
Decision Date:	05/04/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/09/2015

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: Arizona, Michigan
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 female, who sustained an industrial injury on 04/21/2008. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. Diagnoses include thoracic sprain/strain, lumbar sprain/strain, status post lumbar spine surgery, and right wrist sprain/strain. Treatment to date has included home exercise program, medication regimen, laboratory studies, and above listed surgery. In a progress note dated 11/12/2014 the treating provider reports constant low back pain radiating to the left lower extremity with numbness and tingling, constant right wrist/hand pain with numbness and tingling, and frequent mid back pain. The pain to the low back is rated a ten out of ten, the mid back pain is rated a seven to eight out of ten, and the right wrist/hand is rated an eight out of ten. The treating physician requested a transcutaneous electrical nerve stimulation unit to help reduce the need for pain medications and increase range of motion, acupuncture for pain control to the lumbar spine, physical therapy for improvement in range of motion and an increase in strength and flexibility to the lumbar spine, but the documentation did not indicate the reason for the requested pneumatic elevator. On 02/04/2015 Utilization Review modified the requested treatment of acupuncture two times weekly to the lumbar spine with a quantity of 24 to acupuncture two times weekly to the lumbar spine with a quantity of 6 and non-certified the requested treatments of a transcutaneous electrical nerve stimulation unit and supplies for a 30 day trial for a quantity of one, physical therapy two times a week to the lumbar spine with a quantity of 24, and a purchase of a pneumatic home elevator with quantity of one, noting all treatments per 11/12/2014, noting the California Medical Treatment Utilization Schedule:

Chronic Pain Medical Treatment Guidelines: pages 114 to 116; page 99; Acupuncture Medical Treatment Guidelines; and http://www.ncbi.nlm.nih.gov/pubmed/2149926, Title: "A Study on a Design Guide for Detached Houses with Home-Elevators for Aged and Physically Handicapped Persons."

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS (transcutaneous electrical nerve stimulation) unit and supplies, 30 day trial, QTY: 1: 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 Transcutaneous Electrotherapy Page(s): 114-121.

Decision rationale: Per the MTUS, transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality. However it may be tried under specific criteria as documented in the MTUS, which include documentation of pain of at least 3 months duration and there is evidence that other appropriate pain modalities including medication have been tried and failed. A one month trial period should include documentation of how often unit was used, as well as outcomes in terms of pain relief and function and other ongoing pain treatment, a treatment plan including specific short and long term goals of treatment with the unit should be submitted and a 2 lead unit is generally recommended, if a 4 lead unit is recommended, there must be documentation of why this is necessary. A review of the injured workers medical records that are available to me reveals that the injured worker has had a previous request for TENS unit trial, however there is no documentation of outcome in terms of pain relief and function, without this information medical necessity for continued use cannot be established.

Acupuncture, 2 times weekly, lumbar spine, QTY: 24: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) / Acupuncture.

Decision rationale: The MTUS, recommends acupuncture as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and or surgical intervention to hasten functional recovery. 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. Time to produce functional improvement is 3-6 treatments. 1-3 times a week for 1-2 months. Per the ODG acupuncture is recommended as an option for chronic low back pain. " ODG

Acupuncture Guidelines: Initial trial of 3-4 visits over 2 weeks. With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.)" Based on the guidelines the request for acupuncture, 2 times weekly, lumbar spine, QTY: 24 exceeds the guideline recommendations of an initial trial of 3-4 visits and is not medically necessary.

Physical therapy, 2 times weekly, lumbar spine, QTY: 24: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Per the MTUS, physical therapy is recommended following specific guidelines, allowing for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self directed home physical medicine. For myalgia and myositis unspecified the guidelines recommend 9-10 visits over 8 weeks. Neuralgia, neuritis and radiculitis unspecified 8-10 visits over 4 weeks. A review of the injured workers medical records that are available to me do not show documentation of subjective and objective pain and functional improvement with previous physical therapy also the request for physical therapy, 2 times weekly, lumbar spine, QTY: 24 exceeds the guideline recommendations and is not medically necessary.

Purchase of a pneumatic home elevator, QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.ncbi.nlm.nih.gov/pubmed/2149926.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices PMD's) Page(s): 99.

Decision rationale: The MTUS/ACOEM and ODG did not address the use of a pneumatic home elevator and therefore alternate guidelines were consulted. A search for peer reviewed evidence based treatments recommendations on pneumatic home elevator did not reveal any credible findings, therefore an MTUS guideline was adapted for use. Per the MTUS, power mobility devices which a pneumatic home elevator can be categorized as are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker. A review of the injured workers medical records reveal that she is ambulant and has already been prescribed a walker. There is no documentation in the injured workers medical records that are available to me to support the request for a pneumatic home elevator and without this information medical necessity cannot be established.