

Case Number:	CM15-0080290		
Date Assigned:	05/01/2015	Date of Injury:	03/05/2006
Decision Date:	06/09/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/27/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 66 year old female, who sustained an industrial injury on 3/5/2006. She reported injury while trying to open a safe. The injured worker was diagnosed as having prior lumbar laminectomy in 1991 and status post epidural spinal injections. There is no record of a recent diagnostic study. Treatment to date has included epidural steroid injections and medication management. In a progress note dated 3/31/2015, the injured worker complains of back pain 8/10. The treating physician is requesting 12 sessions of acupuncture, 12 sessions of chiropractic care and pain management consultation for medication management.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 sessions of acupuncture: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Acupuncture treatment.

Decision rationale: Pursuant to the Acupuncture Medical Treatment Guidelines and the Official Disability Guidelines, 12 acupuncture sessions is not medically necessary. Acupuncture is not recommended for acute low back pain. Acupuncture is recommended as an option for chronic low back pain using a short course of treatment in conjunction with other interventions. The Official Disability Guidelines provide for an initial trial of 3-4 visits over two weeks. With evidence of objective functional improvement, a total of up to 8 to 12 visits over 4 to 6 weeks may be indicated. The evidence is inconclusive for repeating this procedure beyond an initial short period. In this case, the injured worker's working diagnoses are status post lumbar laminectomy 1991; and status post epidural spinal injections per patient history. The medical record contains 36 pages and a single progress note dated March 31, 2015. The single progress note is the physician's first report. Date of injury is March 5, 2006. There were no past medical records for review. There were no historical treatments documented in the record. According to the March 31, 2015 progress note, subjectively the injured worker at a VAS pain scale of 8/10. The location of pain was not documented in the medical record. Objectively, the progress note states "see attachment". There is no attachment in the medical record. The treating provider requested 12 acupuncture sessions. There is no clinical indication or rationale and no specific subjective objective findings are documented. There is no documentation of prior acupuncture in the medical record. Additionally, the guidelines provide for an initial trial of 3 to 4 visits. The requesting physician exceeded the recommended guidelines. Consequently, absent clinical documentation with subjective and objective findings, a clinical indication and rationale for 12 acupuncture sessions in excess of the recommended guidelines, 12 acupuncture sessions are not medically necessary.

12 sessions of chiropractic treatment: 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 Chiropractic Therapy Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Chiropractic treatment.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, 12 chiropractic sessions are not medically necessary. Manual manipulation and therapy is recommended for chronic pain is caused by musculoskeletal conditions. The intended goal or effective manual medicine is the achievement of positive symptomatic or objective measurable gains and functional improvement. Manipulation, therapeutic care-trial of 6 visits over two weeks. With evidence of objective functional improvement, total of up to 18 visits over 6 to 8 weeks. Elective/maintenance care is not medically necessary. In this case, the injured worker's working diagnoses are status post lumbar laminectomy 1991; and status post epidural spinal injections per patient history. The medical record contains 36 pages and a single progress note dated March 31, 2015. The single progress note is the physician's first report. Date of injury is March 5, 2006. There were no past medical records for review. There were no historical treatments documented in the record. According to the March 31, 2015 progress note, subjectively the injured worker at a VAS pain scale of 8/10. The location of pain was not

documented in the medical record. Objectively, the progress note states "see attachment". There is no attachment in the medical record. The treating provider requested 12 chiropractic sessions. There is no clinical indication or rationale and no specific subjective objective findings are documented. There is no documentation of prior chiropractic treatment in the medical record. Additionally, the guidelines provide for an initial trial of 6 visits. The requesting physician exceeded the recommended guidelines. Consequently, absent clinical documentation with subjective and objective findings, a clinical indication and rationale for 12 chiropractic sessions in excess of the recommended guidelines, 12 chiropractic sessions are not medically necessary.

Pain management consult for medication handling: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): Chapter 7, Pages 127-8.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, pain management consult for medication handling is not medically necessary. An occupational health practitioner may refer to other specialists if the diagnosis is certain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultation is designed to aid in the diagnosis, prognosis and therapeutic management of a patient. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates for certain antibiotics require close monitoring. In this case, the injured worker's working diagnoses are status post lumbar laminectomy 1991; and status post epidural spinal injections per patient history. The medical record contains 36 pages and a single progress note dated March 31, 2015. The single progress note is the physician's first report. Date of injury is March 5, 2006. There were no past medical records for review. There were no historical treatments documented in the record. According to the March 31, 2015 progress note, subjectively the injured worker at a VAS pain scale of 8/10. The location of pain was not documented in the medical record. Objectively, the progress note states "see attachment". There is no attachment in the medical record. There are no medications documented in the medical record. There is no clinical information in the 36 page medical record that will aid in the diagnosis prognosis and therapeutic management of the injured worker with a pain management consultation. Consequently, absent clinical documentation with subjective and objective findings, a list of current medications and a clinical indication and rationale for "medication handling", pain management consultation for medication handling is not medically necessary.