

Case Number:	CM13-0067680		
Date Assigned:	01/03/2014	Date of Injury:	12/11/2002
Decision Date:	05/18/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/18/2013

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 & Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 65 year old male with a work injury dated 12/11/02. He complains of low back, right knee and anterior left knee pain. His diagnoses include lumbar I lumbosacral neuritis, lumbar disc degeneration I thinning and knee tenosynovitis rule out derangement. There are requests for acupuncture 2 x 6; chiro 1 every 3 weeks; EMS 2x6; Myofascial release 2 x 6; electroacupuncture 2 x 6; cupping 2 x 6; infrared lamp 2 x 6; home Tens unit purchase. Per a primary treating physician report on 10/17/13 the patient stated that he has been informed that knee replacement would be beneficial, however due to his health condition of diabetes, CHF, and renal failure he is precluded from surgery of any kind. He stated that chiropractic, physiotherapy, and acupuncture has helped with managing the pain intensity. The patient at this visit complains of lower back pain. The pain is described as aching and dull. The pain is made better by chiropractic treatments, acupuncture, physical therapy, and physical therapy. He states that bending, lifting, prolonged standing, prolonged walking and daily activities of living aggravates the condition. The patient is complaining of anterior right knee pain. The pain is described as sharp and stabbing. He rated this pain as a 6 on a scale of 0 to 10 with 10 being the worst. The pain is reduced by resting while prolonged standing, prolonged walking, walking downstairs, walking upstairs, weight bearing and daily activities of living aggravates the condition. He is complaining of anterior left knee pain. He rated this pain as a 6 on a scale of 0 to 10 with 10 being the worst. The pain is expressed as sharp and stabbing. The pain is reduced by resting while prolonged standing, prolonged walking, walking downstairs, walking upstairs, weight-bearing and daily activities of living aggravates the condition. On physical exam he has decreased lumbar spine and knee range of motion. He has decreased patella reflexes and normal ankle reflexes. On lumbar spine exam, Kemps was positive bilaterally and caused pain. Patrick-Fabere test was positive on the left and the right (increased pain). The following lumbar

orthopedic tests were positive: straight passive on both sides (increased pain at 70 degrees). The following orthopedic tests were negative on the left: anterior drawer and posterior drawer. The following orthopedic tests were positive on the left: Valgus median, Varus lateral and Lachman's (increased pain). The following orthopedic tests were negative on the right: anterior drawer and posterior drawer. The following orthopedic tests were positive on the right: Valgus median, Varus lateral and Lachman's (increased pain).

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE 2X6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Acupuncture 2 x 6 is not medically necessary per the MTUS Acupuncture Medical Treatment Guidelines. The guidelines state that the time to produce functional improvement: 3 to 6 treatments. The request for 2 x 6 treatments would exceed this amount of visits. Furthermore, it is unclear if patient has had acupuncture in the past since his injury was in 2002. Without clear documentation of how much acupuncture patient has had and whether he has received any benefit/functional improvement the request for acupuncture 2 x 6 is recommended non certified and not medically necessary.

CHIRO 1 EVERY 3 WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation Page(s): 58-59.

Decision rationale: Chiro 1 every 3 weeks is not medically necessary per the Chronic Pain Medical Treatment MTUS guidelines. Per guidelines elective/maintenance care is not medically necessary. Therapeutic care involves a trial of 6 visits over 2 weeks, with evidence of objective functional improvement with a total of up to 18 visits. The documentation indicates that the patient has had chiropractic care in the past. Without documentation of specific number of visits he has had in the past and whether there was any functional improvement the request for chiro 1 every 3 weeks is not medically necessary.

EMS 2X6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: EMS is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines Per the guidelines neuromuscular electrical stimulation is used primarily as part of a rehabilitation program following stroke or spinal cord injury and there is no evidence to support its use in chronic pain. The documentation does not indicate that the patient has had a stroke and this was prescribed to the patient for chronic pain. The request for EMS is not medically necessary.

MYOFASCIAL RELEASE 2X6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation Page(s): 58-59.

Decision rationale: Myofascial release 2 x 6 is not medically necessary per the Chronic Pain Medical Treatment MTUS guidelines. Per guidelines, elective/maintenance care is not medically necessary. Therapeutic care involves a trial of 6 visits over 2 weeks, with evidence of objective functional improvement with a total of up to 18 visits. Without documentation of specific number of therapy visits and treatments such as myofascial release, that the patient has had in the past and whether there was any functional improvement the request for Myofascial release 2 x 6 is not medically necessary.

ELECTRO ACUPUNCTURE 2X6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Electro-Acupuncture 2 x 6 is not medically necessary per the MTUS Acupuncture Medical Treatment Guidelines. The guidelines state that the time to produce functional improvement: 3 to 6 treatments. The request for 2 x 6 treatments would exceed this amount of visits. Furthermore, it is unclear if patient has had acupuncture in the past since his injury was in 2002. Without clear documentation of how much acupuncture patient has had and whether he has received any benefit/functional improvement the request for electro-acupuncture 2 x 6 is recommended non certified and not medically necessary.

CUPPING 2X6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 99-100. Decision based on Non-MTUS Citation "Cupping". American Cancer Society. November 2008. Retrieved 4 October 2013 and Singh, Simon; Ernst, Edzard (2008) Trick or Treatment. Transworld Publishers. p. 368. ISBN 9780552157629 and http://en.wikipedia.org/wiki/Cupping_therapy.

Decision rationale: Cupping is not medically necessary. The MTUS and ODG do not address cupping specifically. Other guidelines were referenced. In the 2008 book Trick or Treatment, Simon Singh and Edzard Ernst write that no evidence exists of any beneficial effects of cupping for any medical condition. The American Cancer Society states that cupping is a widely used alternative treatment to cancer but cupping can leave temporary bruised marks on the skin and there is a small risk of burns, additionally: "available scientific evidence does not support claims that cupping has any health benefits." Furthermore, this treatment would be applied during a patient's therapy session. Without documentation of what prior therapy, the patient has had and what functional benefit was achieved from prior therapy sessions, additional therapy cannot be certified. Therefore, the request for cupping is not medically necessary or appropriate.

INFRARED LAMP 2X6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Lumbar Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back & Lumbar & Thoracic (Acute & Chronic)- infrared therapy.

Decision rationale: The request for infrared lamp 2 x 6 is not medically necessary per the ODG guidelines. The ODG guidelines state that infrared therapy is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care. The documentation does not indicate whether patient has attempted other heat modalities. There is no documentation that this will be used as an adjunct to a program of evidence based conservative care. The request for infrared lamp 2 x 6 is not medically necessary.

HOME TENS UNIT PURCHASE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116.

Decision rationale: A home TENS unit for purchase is not medically necessary per the MTUS guidelines. The guidelines state that a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration

approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this time. The documentation submitted does not reveal the documentation of use and outcomes recommended prior to having a rental or home TENS unit. MTUS guidelines recommend TENS "as an adjunct to a program of evidence-based functional restoration." Additionally, there should be "a treatment plan including the specific short and long-term goals of treatment with the TENS unit" documented. The above documentation does not submit evidence of a treatment plan or an ongoing documented program of evidence based functional restoration. The request for a home TENS unit for purchase is not medically necessary.