MAXIMUS Federal Services

Case Number:	CM14-0115618		
Date Assigned:	08/04/2014	Date of Injury:	03/31/2014
Decision Date:	10/28/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/22/2014

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 & 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:

The injured worker is a 40-year-old male who reported an injury on 03/31/2014. The mechanism of injury was not submitted for clinical review. The diagnoses included contusion injury involving right leg and block injection arms, post-traumatic myofascial pain syndrome, right leg sprain/strain injury. His treatments included acupuncture, medication. Within the clinical note dated 06/02/2014 it was reported the injured worker reported improvement with the trial of electroacupuncture treatment. He reported the ability to perform activities and self-care. Upon physical examination the provider noted local tenderness in the right leg and bilateral arm. The motor strength was 5/5 in both upper and lower extremities. Deep tendon reflexes were 2/2. There was light touch sensation present in both upper and lower extremities. The provider requested electroacupuncture, infrared heat, and myofascial release. However, a rationale was not submitted for clinical review. The request for authorization was submitted and dated 06/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electro Acupuncture: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for Electro Acupuncture is not medically necessary. The Acupuncture Treatment Guidelines note acupuncture is used as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease side effects of medication induced nausea, promote relaxation in an anxious patient and reduce muscle spasms. The time to produce effect includes 3 to 6 treatments with a frequency of 1 to 3 times per week. An optimum duration includes 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. While the clinical documentation submitted indicates functional benefit with acupuncture, the request may be indicated, there is lack of documentation of the number of sessions the provider is requesting. The request submitted does not provide a treatment site. Therefore, the request is not medically necessary.

Infrared Heat: 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), Low Back, Infared therapy.

Decision rationale: The request for Infrared Heat is not medically necessary. The Official Disability Guidelines do not recommend infrared therapy over other therapies. While deep heating is desirable, providers may consider a limited trial of ion therapy for treatment of acute low back pain, but only if used as an adjunct to programs of evidence based conservative care. The request submitted failed to provide the number of sessions the provider was indicating for the patient to undergo. The request does not provide a treatment site for therapy. Additionally, the guidelines do not recommend infrared heat therapy over other therapies. Therefore, the request is not medically necessary.

Myofascial Release 2x for 8 weeks Right Leg and Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

Decision rationale: The request for Myofascial Release 2x for 8 weeks Right Leg and Upper Extremities is not medically necessary. The California MTUS Guidelines recommend massage therapy as an option. This treatment should be as an adjunct to other recommended treatments and it should be limited to 4 to 6 visits in most cases. Many studies lack long term followup. Massage is beneficial in attenuating diffuse muscle symptoms, but beneficial effects are

registered only during treatment. The number of sessions requested exceeds the guideline recommendations of 4 to 6 visits in most cases. Additionally, there is a lack of documentation warranting the medical necessity for the request. Therefore, the request is not medically necessary.

Myofascial Release 2x for 8 weeks for the Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

Decision rationale: The request for Myofascial Release 2x for 8 weeks for the Upper Extremities is not medically necessary. The California MTUS Guidelines recommend massage therapy as an option. This treatment should be as an adjunct to other recommended treatments and it should be limited to 4 to 6 visits in most cases. Many studies lack long term followup. Massage is beneficial in attenuating diffuse muscle symptoms, but beneficial effects are registered only during treatment. The number of sessions requested exceeds the guideline recommendations of 4 to 6 visits in most cases. Additionally, there is a lack of documentation warranting the medical necessity for the request. Therefore, the request is not medically necessary.