

Case Number:	CM15-0161139		
Date Assigned:	08/28/2015	Date of Injury:	06/13/2014
Decision Date:	11/12/2015	UR Denial Date:	07/23/2015
Priority:	Standard	Application Received:	08/18/2015

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, Pain Management, 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 25 year old male who sustained an industrial injury on 6-13-14. Diagnoses are dizziness, headache, nausea, lumbar disc protrusion, lumbar radiculitis, lumbar sprain-strain, right hip sprain-strain, left hip sprain-strain, right knee sprain-strain, left knee sprain-strain, fatigue, loss of sleep, anxiety, stress, myofascitis-myalgia, muscle spasm with weakness, contusion-head, and altered gait. A 5-8-15 initial primary treating physician's evaluation and report notes injuries from 6-1-14 to 2-1-15 as the injured worker reports a beam fell from a trailer, striking him on the head, and he was then crushed by multiple boxes weighing approximately 75 pounds each. He sustained injuries to his head, lower back, knees and hips. In a progress report dated 6-15-15, the primary treating physician notes complaints of frequent temporal, frontal, dizziness and nausea, low back pain with radiation down bilateral legs, right and left hip pain, right and left knee pain, anxiety, stress, and loss of sleep due to pain. Cranial nerves II through VII and XII were tested and were within normal limits. Lumbar spine range of motion is decreased and painful and tenderness to palpation and muscle spasm is noted. Kemp's and straight leg raise are positive. The right and left hip ranges of motion are decreased and painful and FABER test is positive. Work status is to remain off work until 7-30-15. The requested treatment is acupuncture treatment 2 times a week for 6 weeks, chiropractic 1 time a week for 4 weeks, physiotherapy 1 time a week for 4 weeks, shock wave 1 time a week for 6 weeks, psych as needed, behavioral therapy as needed, and sleep study as needed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture treatment 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: MTUS 2009 recommends up to 6 sessions of acupuncture as an initial trial. This request exceeds MTUS 2009 guidelines without any justification why the additional acupuncture is medically necessary. Therefore, this request for 12 sessions of acupuncture is not medically necessary.

Chiropractic 1 time a week for 4 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: MTUS 2009 recommends an initial trial of manual therapy to treat painful musculoskeletal disorders. This request for 4 sessions of chiropractic care adheres to MTUS 2009. As such, this request is medically necessary.

Physiotherapy 1 time a week for 4 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: MTUS 2009 recommends from 8 to 10 sessions of therapy to treat myalgias. It appears that 8 sessions of PT may have already been provided but the medical records do not describe whether they have been done. Therefore, this request for 4 sessions of therapy adheres to MTUS 2009 and is medically necessary.

Shock wave 1 time a week for 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back Chapter - Lumbar & Thoracic (Acute & Chronic) (updated 7/17/2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shockwave Therapy.

Decision rationale: ODG recommends against shock wave therapy to treat lower back pain. It states that there is no evidence supporting its use and that use of shock wave therapy to treat lower back pain should be discouraged. The medical record does not explain why shock wave therapy should be provided in this case when evidence based guidelines recommend against its use making it medically unnecessary.

Psych as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Behavioral interventions.

Decision rationale: MTUS 2009 recommends up to six sessions of CBT to assist with coping for chronic pain. This request does not specify a frequency or duration. Therefore, this request for psych as needed is not medically necessary. There are no specific diagnoses or goals associated with this request.

Behavioral therapy as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Behavioral interventions.

Decision rationale: MTUS 2009 recommends up to six sessions of CBT to assist with coping for chronic pain. This request does not specify a frequency or duration. Therefore, this request for psych as needed is not medically necessary. There are no specific diagnoses or goals associated with this request.

Sleep study as needed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Polysomnography.

Decision rationale: ODG states that sleep studies are indicated for symptoms of narcolepsy or sleep apnea. Neither condition is supported by the information contained in the medical record. Therefore this request for a sleep study is not medically necessary.