

Case Number:	CM15-0170580		
Date Assigned:	09/11/2015	Date of Injury:	01/29/2014
Decision Date:	10/08/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	08/31/2015

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, California

Certification(s)/Specialty: Family Practice

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 38-year-old female, who sustained an industrial-work injury on 1-29-14. She reported initial complaints of back, right wrist, and hip pain. The injured worker was diagnosed as having right wrist strain, repetitive strain injury, and lumbar sprain and strain. Treatment to date has included medication, and prior electro-acupuncture treatment (6 sessions). Currently, the injured worker complains of constant low back pain with radiation to the hips with intermittent right wrist pain. Per the primary physician's progress report (PR-2) on 8-5-15, lumbar exam noted positive straight leg raise, decreased lumbar range of motion, normal deep tendon reflexes and motor strength. The right wrist exam was positive for tenderness and swelling, full range of motion, and motor strength was 5- out of 5. Current plan of care includes additional acupuncture for conservative treatment. The Request for Authorization date was 8-5-15 and requested service included Electro acupuncture 2 times a week for 6 weeks for the lumbar and right wrist, Infrared 2 times a week for 6 weeks for the lumbar and right wrist, and Myofascial release 2 times a week for 6 weeks for the lumbar and right wrist. The Utilization Review on 8-18-15 denied the request for electro acupuncture per CA MTUS guidelines due to lack of evidence of functional improvement. Infrared is denied and not medically necessary, and myofascial release is also not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electro acupuncture 2 times a week for 6 weeks for the lumbar and right wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Time to produce functional improvement: 3 to 6 treatments. In this case, the claimant has already undergone electro acupuncture. Although the optimal duration may be 1-2 months, the progress notes were not provided to support additional use. Acupuncture is considered an option and not a medical necessity.

Infrared 2 times a week for 6 weeks for the lumbar and right wrist: 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): Low-Level Laser Therapy (LLLT).

Decision rationale: According to the guidelines, low-level lasers are not recommended. Infrared therapy refers to a low-level laser. In this case, the claimant had undergone medications and acupuncture. There is insufficient evidence to support the use of Infrared for the wrist or back. The reason for use was not substantiated or justified. The request is not medically necessary.

Myofascial release 2 times a week for 6 weeks for the lumbar and right wrist: 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): Manual therapy & manipulation, Massage therapy.

Decision rationale: Myofascial release can be offered through manual therapy or massage therapy. The amount of sessions recommended is 4-6 visits. It is generally not recommended for the wrist. The amount of sessions requested exceeds the amount recommended to determine benefit. The request for 12 sessions is not medically necessary.