

Case Number:	CM15-0048460		
Date Assigned:	03/20/2015	Date of Injury:	08/15/2014
Decision Date:	05/01/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	03/13/2015

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: Chiropractor, Oriental 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 35 year old male, who sustained an industrial injury on 08/15/2014. He has reported injury to the low back. The diagnoses have included lumbar sprain/strain and lumbar radiculopathy. Treatment to date has included medications, acupuncture, chiropractic sessions, and physical therapy. A progress report from the treating provider, dated 01/14/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of frequent severe low back pain with stiffness; and pain relief from medication and rest. Objective findings included tenderness to palpation of the bilateral sacroiliac joints and lumbar paravertebral muscles; muscle spasm of the bilateral gluteus and lumbar paravertebral muscles; and straight leg raise is positive. The treatment plan included prescription medications. The current request is for Acupuncture 8 visits 2 times a week for 4 weeks, Lumbar and/or Sacral Vertebrae; Infrared Therapy 8 visits 2 times a week for 4 weeks, Lumbar and/or Sacral Vertebrae; and Chiropractor 8 visits 2 times a week for 4 weeks, Lumbar and/or Sacral Vertebrae.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 8 visits 2 times a week for 4 weeks, Lumbar and/or Sacral Vertebrae (Vertebra NOC Trunk): Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The medical records reflect initiation of Acupuncture care in the PR-2 of/request for care dated 11/14/14. Care was requested to manage lumbar spine/sprain/strain arising from a work related injury on 8/15/14. Subsequent Acupuncture was requested on 1/22/15 for management of reported lumbar radiculopathy. The UR determination denied the request for additional care citing CA MTUS Acupuncture Treatment Guidelines. The reviewed medical records did not establish the medical necessity for further care with objective clinical evidence of functional improvement. Evidence of functional improvement is required at the time of any additional request for care after the initial 6 sessions of care. The request is not medically necessary.

Infrared Therapy 8 Visits 2 times a week for 4 weeks, Lumbar and/or Sacral Vertebrae (Vertebra NOC Trunk): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG TWC: ODG Treatment Integrated Treatment/Disability Duration Guidelines Neck and Upper Back/lumbar (Acute & Chronic) Updated 11/18/14).

Decision rationale: The UR determination denied the use of infrared therapy in conjunction with either Acupuncture management of lower back pain or Acupuncture for management of the same condition. The patient's presentation for care did not reflect the medical necessity for deep heat therapy to manage demonstrated soft tissue deficits. This request is not medically necessary.

Chiropractor 8 visits 2 times a week for 4 weeks, Lumbar and/or Vertebrae (Vertebra NOC Trunk): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 2009; 9294.2; manual therapy and manipulation Page(s): 58/59.

Decision rationale: The UR determination recommended denial of requested Chiropractic care, 8 additional sessions based on CA MTUS Chronic Treatment Guidelines and reviewed medical records. The reviewed medical records failed to address any objective clinical evidence of functional improvement provided with the prior course of Chiropractic treatment as required by the referenced CA MTUS Chronic Treatment Guidelines. Records reviewed failed to establish the medical necessity to continue Chiropractic care that was not supported by CA MTUS Chronic Treatment Guidelines. Therefore, the request is not medically necessary.