Case Number:	CM13-0010865		
Date Assigned:	03/26/2014	**Date of Injury:**	08/29/2011
Decision Date:	06/10/2014	**UR Denial Date:**	07/30/2013
Priority:	Standard	**Application Received:**	08/14/2013

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 licensed in Chiropractic 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 patient is a 57-year-old male whose date of injury is 08/29/2011. The patient developed cumulative trauma injury to the low back and bilateral knees as a result of kneeling, breaking concrete and laying down drywall. The treatment to date includes chiropractic, shockwave treatment, and cortisone injections to the knees. An MRI of the lumbar spine dated 02/01/13, revealed disc desiccation at L5-S1 with Modic type II endplate degenerative changes involving the inferior endplate of L2 and the superior endplate of L3. An MRI of the right knee dated 02/01/13, revealed linear increased signal in the posterior horn of the medial meniscus, which extends to the inferior articular surface consistent with the tear; small knee effusion. An MRI of the left knee dated 02/01/13, revealed some linear increased signal in the posterior horn of the medial meniscus suggesting internal degeneration with possible tear not excluded; some increased signal interest to the medial of midline beneath the tibial spine; the anterior cruciate ligament appears somewhat thinned suggesting possible chronic sprain or old partial tear. An electromyography/nerve conduction velocity (EMG/NCV) dated 02/06/13, revealed findings consistent with bilateral carpal tunnel syndrome, bilateral ulnar neuropathies at the wrists and a possible cervical radiculopathy. The nerve conduction studies dated 04/03/13, revealed findings consistent with lumbosacral plexopathy with an L5-S1 radiculopathy. The patient underwent left knee arthroscopy on 10/11/13. The progress note dated 10/24/13 indicates that the patient was referred for physical therapy. The patient subsequently underwent trigger point injections in February 2014. The patient underwent right knee partial medial meniscectomy on 02/28/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL ACUPUNCTURE, DURATION UNSPECIFIED: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DIABILITY GUIDELINES (ODG), ACUPUNCTURE GUIDELINES, ACOEM PRACTICE GUIDELINES, APG INSIGHTS, WINTER 2005, TEXT, PAGE 5-9, AND THE OFFICIAL DISABILITY GUIDELINES (ODG), ONLINE EDITION (HTTP://WWW.ODG-TWC.COM/ODGTWCLIST.HTM).

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The submitted records indicate that the patient has undergone extensive acupuncture to date, at least thirty (30) visits between April 2013 and February 2014. There are no significant objective measures of improvement documented to establish efficacy of treatment and support additional treatment sessions. The serial acupuncture notes indicate that the patient's subjective pain level remained 7/10 on the visual analog scale (VAS). The Acupuncture Medical Treatment Guidelines indicate that optimum duration of treatment is one to two (1-2) months. There is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented.