

<b>Case Number:</b>	CM13-0026198		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	04/23/2007
<b>Decision Date:</b>	01/30/2014	<b>UR Denial Date:</b>	09/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine, has a subspecialty in Pulmonary Disease 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 physician 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 female who reported an injury on 04/23/2007. The mechanism of injury was not provided for review. However, this injury resulted in a lumbar fusion of the L4, L5, and S1 level and carpal tunnel syndrome status post-surgical release. Previous treatments included physical therapy, a TENS unit, medications, and epidural steroid injections. The patient complained of chronic low back pain with complaints of radicular symptoms. The patient also received psychological support for her chronic depression in the way of counseling and pet therapy. The patient's most recent clinical examination findings included low back pain complaints rated at 10/10. Physical findings included decreased sensation in the hands and L4, L5, and S1 dermatomes with a positive Phalen's and Tinel's test bilaterally and reduced range of motion of the lumbar spine secondary to pain. The patient's diagnoses included low back pain status post fusion at the L4-5 in 2008, multiple lumbar radiculopathy affecting L4, L5, and S1, and bilateral carpal tunnel syndrome status post-surgical release. The patient's treatment plan included an additional lumbar epidural steroid injection, a Functional Capacity Evaluation, acupuncture, psychiatric support, massage therapy, and continued medication usage.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Request for treatment of lumbar spine TESI x 1 series L5-S1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**Decision rationale:** The requested treatment of lumbar spine TESI x 1 series L5-S1 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has previously received epidural steroid injections. The California Medical Treatment and Utilization Schedule recommends repeat injections be based on objective documentation of pain relief and functional improvement to include at least 50% pain relief with associated reduction in medications for at least 6 to 8 weeks. The clinical documentation submitted for review does not provide any quantitative or objective descriptions of functional improvement or pain relief, reduction in pain medication related to prior injections, or duration of pain relief. Additionally, there is no documentation that the patient is participating in any type of active therapy that would benefit from the addition of a lumbar epidural steroid injection for pain relief. As such, the requested treatment of lumbar spine TESI x 1 series L5-S1 is not medically necessary or appropriate.

**Request for acupuncture 2 times a week for 4 weeks for the low back:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The requested acupuncture 2 times a week for 4 weeks for the low back is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient was previously referred to acupuncture; however, she did not receive this therapy due to complications with psychiatric care. The California Medical Treatment and Utilization Schedule recommends acupuncture as an adjunct therapy to physical rehabilitation to promote functional recovery when medication is reduced or not tolerated. The clinical documentation submitted for review does not provide any evidence that the patient is actively participating in physical rehabilitation to include a home exercise program. Additionally, there is no indication that the patient has recently had a reduction in medication. Also, the California Medical Treatment and Utilization Schedule recommends an adequate trial of 3 to 6 treatments to support the efficacy of this treatment modality. The request exceeds this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond Guideline recommendations. As such, the requested acupuncture 2 times a week for 4 weeks for the low back is not medically necessary or appropriate.

**Request for massage therapy 2 times a week for 4 weeks for the low back:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The requested massage therapy 2 times a week for 4 weeks for the low back is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has continued low back pain with radicular symptoms. The California Medical Treatment and Utilization Schedule date of service recommend up to 3 to 4 treatments of massage therapy to assist with pain control as an adjunct treatment to an active therapy program. The clinical documentation submitted for review does not provide any evidence that the patient is participating in an active therapy program such as a home exercise program. Additionally, the request is for 2 times a week for 4 weeks, which exceeds the recommendation of 4 to 6 visits. There are no exceptional factors noted within the documentation to support extending treatment beyond Guideline recommendations. As such, the requested massage therapy 2 times a week for 4 weeks for the low back is not medically necessary or appropriate.

**Request for functional capacity evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 77-79. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluations.

**Decision rationale:** The requested functional capacity evaluation is not medically necessary or appropriate. The clinical documentation submitted for review does support that the patient is not currently working as a result of her compensable injury. The American College of Occupational and Environmental Medicine recommends the use of a Functional Capacity Evaluation to obtain a more precise delineation of patient capabilities than is available from routine physical examination and notes. However, the clinical documentation submitted for review does not provide any evidence that the patient intends to return to work. The Official Disability Guidelines do not recommend a Functional Capacity Evaluation for the sole purpose of determining a worker's effort or compliance or if the patient is not at or close to maximum medical improvement. The clinical documentation submitted for review does not provide any evidence that the patient is at or near maximum medical improvement or has a job with the intention to return to work. As such, the requested functional capacity evaluation is not medically necessary or appropriate.