

<b>Case Number:</b>	CM13-0068592		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	09/22/2006
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	11/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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 Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, 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 60-year-old with date of injury September 22, 2006. The treating physician report dated October 31, 2013 indicates that the patient presents with chronic pain affecting the cervical 6/10, thoracic 3-4/10 and lumbar spine 7/10. The current diagnoses are multi level L/S discs, lumbar myofascitis, lumbar - left sciatica, C/S multi level discs herniated, and lumbar facet syndrome. The utilization review report dated November 21, 2013 denied the request for 6 sessions of electro acupuncture, one trigger point injection at the left S/I joint, Chiropractic therapy 1x1, Infrared lamp acupuncture 1x6 and W-C cupping acupuncture 1x6 based on lack of medical necessity and no documentation of prior functional gains with similar treatments.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **W-C ELECTRO-ACUPUNCTURE, SIX SESSIONS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Acupuncture Medical Treatment Guidelines, ,

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

**Decision rationale:** The patient presents with chronic pain affecting the cervical, thoracic and lumbar spine. The current request is for W-C Electro-Acupuncture six sessions. Review of the

treating physician report dated October 31, 2013 requests six electro acupuncture sessions along with infrared lamp usage during the acupuncture and cupping to be performed during the acupuncture. In reviewing the treating physician reports dated July 16, September 3, and October 31, 2013 there are consistent prescriptions for electro acupuncture. However, none of the reports provide any information regarding the patient's response to care, reduction of pain or functional improvement. Review of the Acupuncture Medical Treatment Guidelines (AMTG) recommends acupuncture treatment for spinal complaints. The AMTG states that if acupuncture treatments are to be extended then there must be documented functional improvement. The Acupuncture Medical Treatment Guidelines does not support on-going acupuncture treatments without documentation of functional improvement. Functional improvement per labor code 9792.20(e) require significant change in ADL's (activities of daily living), improvement in work status and decreased dependence of other treatments. In this case, the treater documents that the patient has decreased pain with medications, chiropractic and rest. There is not documentation of any response to prior acupuncture treatments and no functional improvements are noted. The request for W-C electro-acupuncture, six sessions, is not medically necessary or appropriate.

**ONE TRIGGER POINT INJECTION AT THE LEFT SACROILIAC JOINT: 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 Trigger point injections Page(s): 122.

**Decision rationale:** The patient presents with chronic pain affecting the cervical, thoracic and lumbar spine. The current request is for one trigger point injection at the left sacroiliac joint. The treating physician report dated Octoebr 31, 2013 has no objective reporting regarding any sacroiliac testing or findings. The treater states, "The lumbar spinal region reveals tender areas in the lumbar region on both sides (grade 3). Palpation of the lumbar musculature demonstrates hypertonicity in that area in the lumbar region on both sides (moderate) and erector spinae on both sides (moderate)." The Chronic Pain Medical Treatment Guidelines states: "Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain." In this case, the treater does not document any trigger points affecting the left sacroiliac joint. Without the specific documentation of trigger points and it's features on examination, these injections are not supported by the Chronic Pain Medical Treatment Guidelines. The request for one trigger point injection at the left sacroiliac joint is not medically necessary or appropriate.

**CHIROPRACTIC THERAPY FOR THREE TO FOUR AREAS, ONCE PER MONTH FOR ONE MONTH: Overturned**

**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 Manual therapy & manipulation Page(s): 56-60.

**Decision rationale:** The patient presents with chronic pain affecting the cervical, thoracic and lumbar spine. The current request is for chiropractic therapy for three to four areas once per month for one month. The October 31, 2013 report states, "Posterior neck pain is lessened by medication, chiropractic treatments and resting." There is no specific documentation of dates that the patient has received chiropractic treatment. Review of the May 1, July 16, and September 3, 2013 reports do not show that chiropractic treatment was requested or performed during this time period. The Chronic Pain Medical Treatment Guidelines for manipulation states, "Recurrences/flare-ups - Need to re-evaluate treatment success, if RTW achieved then one to two visits every four to six months. There is no documentation of any recent chiropractic treatment found in the records provided. The request for one chiropractic treatment is supported by the Chronic Pain Medical Treatment Guidelines. The request for chiropractic therapy for three to four areas, once per month, is medically necessary and appropriate.

**INFRARED LAMP ACUPUNCTURE, ONCE PER WEEK FOR SIX WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Acupuncture Medical Treatment Guidelines, ,

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

**Decision rationale:** The patient presents with chronic pain affecting the cervical, thoracic and lumbar spine. The current request is for Infrared lamp during W-C Electro-Acupuncture 6 sessions. Review of the treating physician report dated October 31, 2013 requests 6 electro acupuncture sessions along with infrared lamp usage during the acupuncture and cupping to be performed during the acupuncture. In reviewing the treating physician reports dated July 16, September 3, and October 31, 2013, there are consistent prescriptions for electro acupuncture. However, none of the reports provide any information regarding the patient's response to care, reduction of pain or functional improvement. Review of the Acupuncture Medical Treatment Guidelines (AMTG) recommends acupuncture treatment for spinal complaints. The AMTG states that if acupuncture treatments are to be extended then there must be documented functional improvement. The AMTG does not support on-going acupuncture treatments without documentation of functional improvement. Functional improvement per labor code 9792.20(e) require significant change in ADL's (activities of daily living), improvement in work status and decreased dependence of other treatments. In this case, the treater documents that the patient has decreased pain with medications, chiropractic and rest. There is not documentation of any response to prior acupuncture treatments and no functional improvements are noted. The request for acupuncture 6 visits was not recommended for authorization and the need for infrared lamp usage during acupuncture would therefore not be supported. The request for infrared lamp acupuncture, once per week for six weeks, is not medically necessary or appropriate.

**W-C CUPPING ACUPUNCTURE, ONCE PER WEEK FOR SIX WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Acupuncture Medical Treatment Guidelines, ,

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

**Decision rationale:** The patient presents with chronic pain affecting the cervical, thoracic and lumbar spine. The current request is for Cupping during W-C Electro-Acupuncture 6 sessions. Review of the treating physician report dated October 31, 2013 requests 6 electro acupuncture sessions along with infrared lamp usage during the acupuncture and cupping to be performed during the acupuncture. In reviewing the treating physician reports dated July 16, September 3, and October 31, 2013 there are consistent prescriptions for electro acupuncture. However, none of the reports provide any information regarding the patient's response to care, reduction of pain or functional improvement. Review of the Acupuncture Medical Treatment Guidelines (AMTG) recommends acupuncture treatment for spinal complaints. The AMTG states that if acupuncture treatments are to be extended then there must be documented functional improvement. The AMTG does not support on-going acupuncture treatments without documentation of functional improvement. Functional improvement per labor code 9792.20(e) require significant change in ADL's, improvement in work status AND decreased dependence of other treatments. In this case, the treater documents that the patient has decreased pain with medications, chiropractic and rest. There is not documentation of any response to prior acupuncture treatments and no functional improvements are noted. The request for acupuncture six visits was not recommended for authorization and the need for Cupping during acupuncture would therefore not be supported. The request for W-C cupping acupuncture, once per week for six weeks, is not medically necessary or appropriate.