

<b>Case Number:</b>	CM14-0035551		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	09/19/2011
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2014

### 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, and is licensed to practice in Illinois. 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 injured worker is a 55-year-old who reported an injury September 19, 2011. The mechanism of injury was not provided within the medical records. The clinical note dated March 4, 2014 indicated diagnoses of lumbar disc protrusion, lumbar musculoligamentous injury, lumbar radiculopathy, and sleep disturbance. The injured worker reported constant severe achy throbbing low back pain that radiated to the left leg with numbness and tingling, aggravated by standing, walking, and bending. He reported loss of sleep due to pain. On physical examination, there was 3+ tenderness to palpation of the lumbar paravertebral muscles with muscle spasms of the lumbar paravertebral muscles, straight leg raise caused pain on the left. The injured worker's prior treatments included diagnostic imaging and chiropractic therapy. The provider submitted a request for acupuncture, chiropractic treatment, physical therapy, and urine drug screen. A Request for Authorization dated March 4, 2014 was submitted for acupuncture, physical therapy, chiropractic therapy, and a urine drug screen. However, a rationale was not provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture two times per week for six weeks.:** Upheld

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

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

**Decision rationale:** The Acupuncture Medical Treatment Guidelines recommend acupuncture 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. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Time to produce functional improvement is three to six treatments. Frequency is one to three times per week. Optimum duration is one to two months. Acupuncture treatments may be extended if functional improvement is documented. There is a lack of clinical documentation indicating the injured worker did not tolerate medications or a reduction of pain medications. In addition, there is a lack of an objective assessment of other injured worker's pain level, functional status, and functional deficits. In addition, the request did not provide a site for the acupuncture. The request for acupuncture two times per week for six weeks is not medically necessary or appropriate.

**Chiropractic treatment two visits.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines:low back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Manipulation and Therapy Page(s): 58.

**Decision rationale:** The California Chronic Pain Medical Treatment Guidelines states the intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The guidelines also state for recurrences/flare-ups - Need to reevaluate treatment success. There is a lack of documentation of functional improvement and efficacy. In addition, there is a lack of objective clinical findings or functional deficits in the documentation submitted. Moreover, the request does not specify a body part. The request for a chiropractic treatment, two visits, is not medically necessary or appropriate.

**Physical Therapy two times per week for six weeks.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines: Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** The California Chronic Pain Medical Treatment Guidelines states active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The completed chiropractic therapy should have been adequate to improve functionality

and transition the injured worker to a home exercise program where the injured worker may continue with exercises such as strengthening, stretching, and range of motion. In addition, the request does not indicate a body part for the physical therapy. The request for a physical therapy two times per week for six weeks is not medically necessary or appropriate.

**Urine drug screen.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines: Before a therapeutic trial of opioids & on going management of Opioids Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines: Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Test Page(s): 43.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend a urine drug test as an option to assess for the use or the presence of illegal drugs. It may also be used in conjunction with a therapeutic trial of Opioids, for on-going management, and as a screening for risk of misuse and addiction. The documentation provided did not indicate the injured worker displayed any aberrant behaviors, drug seeking behaviors, or whether the injured worker was suspected of illegal drug use. In addition, it was not indicated when the last urine drug screen was performed. Additionally, there is no evidence of opioid use. There was a lack of documentation of current medication use in the documentation provided. The request for a urine drug screen is not medically necessary or appropriate.