

<b>Case Number:</b>	CM14-0063337		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	10/15/2004
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	04/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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 Texas. 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 57 year old male whose date of injury is 10/15/2004. The mechanism of injury is not described. Diagnoses are chronic thoracic pain, lumbar strain and muscle spasm. Follow up note dated 06/17/14 indicates that he has completed 6 acupuncture visits. He has also been performing pool exercises twice weekly. On physical examination strength is 5/5 in the bilateral upper and lower extremities. Sensory examination is normal. Deep tendon reflexes are 2+ bilaterally.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture, twice weekly thoracic and lumbar spine QTY: 12.00:** Upheld

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

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

**Decision rationale:** Based on the clinical information provided, the request for acupuncture twice weekly thoracic and lumbar spine qty 12 is not recommended as medically necessary. The injured worker has undergone previous sessions of acupuncture; however, there are no objective measures of improvement to establish efficacy of treatment and support additional sessions as required by California Medical Treatment Utilization Schedule guidelines. California Medical

Treatment Utilization Schedule guidelines note that maximum duration of treatment is 1-2 months, and there is no clear rationale provided to support exceeding this recommendation. Therefore, this request is not medically necessary.

**Behavioral pain management QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 101 and 102 of 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Behavioral interventions Page(s): 23.

**Decision rationale:** Based on the clinical information provided, the request for behavioral pain management qty 1 is not recommended as medically necessary. There is no behavioral evaluation submitted for review with a working diagnosis and individualized treatment plan for this injured worker. There is no clear rationale provided to support this request at this time. Therefore, the request is not in accordance with California Medical Treatment Utilization Schedule guidelines, and medical necessity is not established. Therefore, this request is not medically necessary.

**H wave QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HTW) Page(s): 117 and 118 of 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation Page(s): 117-118.

**Decision rationale:** Based on the clinical information provided, the request for H-wave is not recommended as medically necessary. The submitted records fail to establish that the injured worker has undergone a successful trial of the unit to establish efficacy of treatment as required by California Medical Treatment Utilization Schedule guidelines. There are no specific, time-limited treatment goals provided. Therefore, this request is not medically necessary.

**Repeat ESI QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 45 and 46 of 127.

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

**Decision rationale:** Based on the clinical information provided, the request for repeat epidural steroid injection is not recommended as medically necessary. The injured worker's physical examination fails to establish the presence of active radiculopathy, and there are no imaging studies/electrodiagnostic results submitted for review as required by California Medical

Treatment Utilization Schedule guidelines. Additionally, the submitted records fail to document at least 50% pain relief for at least 6 weeks after prior epidural steroid injection as required by California Medical Treatment Utilization Schedule. Therefore, this request is not medically necessary.