

<b>Case Number:</b>	CM15-0184953		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	06/28/2014
<b>Decision Date:</b>	11/03/2015	<b>UR Denial Date:</b>	09/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Oriental Medicine

### 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 44 year old male, who sustained an industrial injury on 06-28-2014. He has reported injury to the bilateral wrists, bilateral hips, left leg, and low back. The diagnoses have included low back pain; lumbar sprain-strain; lumbar disc displacement; radiculitis, lower extremity; sacroiliac region sprain-strain; wrist sprain-strain; and stenosing tenosynovitis. Treatment to date has included medications, diagnostics, acupuncture, chiropractic therapy, and physical therapy. Medications have included Dicoprofanol, Deprizine, Fanatrex, Synapryn, Tabradol, Ketoprofen cream, and Cyclobenzaprine cream. A progress report from the treating provider, dated 06-19-2015, documented a follow-up visit with the injured worker. The injured worker reported lower back pain with radiation to the right and left lower extremities and knees; and the pain is improving. Objective findings included pain and myospasm to palpation of the right and left paravertebral region of the lumbosacral spine; there is pain to palpation to the right and left sacroiliac joint; ranges of motion are decreased; right and left Kemp's tests are positive for lumbar spine pain; right and left Patrick Fabere's tests are positive for back pain; and right and left Yeoman's tests are positive for back pain. In an acupuncture progress evaluation, dated 06-17-2015, the injured worker rated his pain at 6 out of 10 in intensity to the low back; pain with daily activities is rated at 6 out of 10; and his pain has improved. In an acupuncture progress evaluation, dated 07-22-2015, the injured worker rated his pain at 5 out of 10 in intensity to the low back; pain with daily activities is rated at 5 out of 10; and his pain has improved. The treatment plan has included the request for 8 acupuncture visits to include acupuncture, electrical stimulation acupuncture, massage and infrared therapy. The original utilization review, dated 09-

08-2015, non-certified the request for 8 acupuncture visits to include acupuncture, electrical stimulation acupuncture, massage and infrared therapy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**8 acupuncture visits to include acupuncture, electrical stimulation acupuncture, massage and infrared therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** The guidelines note that the amount of acupuncture to produce functional improvement is 3 to 6 treatments. The same guidelines read extension of acupuncture care could be supported for medical necessity "if functional improvement is documented as either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment." An unknown number of prior acupuncture sessions (combined with electrical stimulation acupuncture, massage and infrared therapy) were rendered in the past without documentation of any significant, objective functional improvement (medication intake reduction, work restrictions reduction, activities of daily living improvement) obtained with prior acupuncture provided to support the appropriateness of the additional acupuncture requested. Also, the request is for acupuncture x 8, number that exceeds the guidelines criteria without any compelling, extraordinary circumstances documented to override the guidelines recommendations. Therefore, the additional acupuncture x 8 combined with electrical stimulation acupuncture, massage and infrared therapy is not medically necessary.