

<b>Case Number:</b>	CM15-0047606		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	10/08/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 46 year old female, who sustained an industrial injury on 10/8/14. She reported pain in the neck, back and upper extremities. The injured worker was diagnosed as having cervical spine sprain, lumbar radiculopathy, lumbar disc protrusion and bilateral wrist/hand sprain. Treatment to date has included acupuncture x 11 treatments, MRI, x-ray and pain medications. As of the PR2 dated 1/30/15, the injured worker reports pain in the neck that radiates to the left upper extremity and back pain. The treating physician requested additional acupuncture treatments 2 x week for 6 weeks and a supervised functional restoration program 2 x week for 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional Acupuncture Sessions 2 Times A Week for 6 Weeks:** Upheld

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

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

**Decision rationale:** The patient presents with pain affecting the back, and neck with radiation to the left upper extremity. The current request is for Additional Acupuncture Sessions 2 Times A Week for 6 Weeks. The treating physician report dated 1/30/15 (24C) states, "To date, she has completed 11 sessions of acupuncture." Review of the Acupuncture Medical Treatment Guidelines (AMTG) supports acupuncture for 3-6 treatments and treatments may be extended if functional improvement is documented. The guidelines go on to state "Frequency: 1 to 3 times per week, Optimum duration: 1 to 2 month." In this case, the patient has received 11 sessions of acupuncture previously, and the current request for an additional 12 treatments exceeds the 3-6 recommended by the AMTG. Furthermore, there was no documentation of functional improvement or the efficacy of previous acupuncture treatments in treating the patient's symptoms. Therefore, the request is not medically necessary.

**Supervised Functional Restoration Program Sessions 2 Times A Week for 6 Weeks:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program Page(s): 49.

**Decision rationale:** The patient presents with pain affecting the back, and neck with radiation to the left upper extremity. The current request is for Supervised Functional Restoration Program Sessions 2 Times A Week for 6 Weeks. The treating physician report dated 1/30/15 (24C) states, "We will continue (The patient) with her functional restoration at 2 times a week for the next 6 weeks." The MTUS guidelines page 49 recommends functional restoration programs and indicate it may be considered medically necessary when all criteria are met including (1) adequate and thorough evaluation has been made; (2) Previous methods of treating chronic pain have been unsuccessful; (3) significant loss of ability to function independently resulting from the chronic pain; (4) not a candidate for surgery or other treatments would clearly be; (5) The patient exhibits motivation to change; (6) Negative predictors of success above have been addressed. The negative factors include the following: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain. In this case, only one medical report was provided for review and the evaluation does not discuss the patient's motivation to change, nor is there any discussion regarding the negative factors. Furthermore, there is no documentation of functional improvement from previous functional restoration program sessions in the reports provided for review. The MTUS requires much more documentation to support the current request for a functional restoration program. Therefore, the request is not medically necessary.