

<b>Case Number:</b>	CM14-0212340		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	07/19/2002
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2014

### 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. 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: 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:

This patient is a 64 year old female with a date of injury of 7/19/02. According to progress report dated 9/17/14, the patient presents with low back pain over the right side that radiates to the right hip. X-rays of the lumbar spine performed on 06/15/2012 showed moderate degenerative disk narrowing at L5-S1. MRI of the pelvis performed on 05/24/2012 showed status post right sacroiliac joint fusion with postsurgical changes. MRI of the lumbar spine performed on 04/20/2011 showed moderate disk desiccation at L1 with mild degeneration from L2-L4. Physical examination of the lumbar spine revealed positive straight leg raise on the right at approximately 60 degrees. There was facet joint tenderness on the right. Facet loading test is positive on the right and there is sciatic notch tenderness bilaterally. Range of motion is restricted and painful. The listed diagnoses are: 1. Chronic pain due to trauma. 2. Chronic pain syndrome. 3. Lumbago. 4. Lumbosacral spondylosis without myelopathy. 5. Bursitis disorder. 6. Dietary surveillance and counseling. 7. Obesity. 8. Essential hypertension, benign. 9. Hyperlipidemia. 10. Adjustment disorder with mixed anxiety and depressed mood. Treatment plan is for patient to continue Naprosyn 375 mg twice a day and acupuncture 6 sessions. The utilization review denied the request on 12/11/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture (6-sessions): 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 Acupuncture Medical Treatment Guidelines Page(s): 13.

**Decision rationale:** This patient presents with right-sided low back pain that radiates into the right hip. The current request is for acupuncture (6sessions). For acupuncture, the MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. Recommended frequency and duration is 3 to 6 treatments for trial and with functional improvement, 1 to 2 times per month. For additional treatment, the MTUS Guidelines require functional improvement as refined by labor code 9792.20 (e) a significant improvement in ADLs, or change in work status and reduced dependence on medical treatments. The number of treatments received to date and the objective response to treatment has not been provided in the medical file provided for review. According to progress report dated 09/17/2014, patient treatment history includes acupuncture. In this case, functional improvements from prior sessions have not been documented to consider additional acupuncture treatments. The requested additional acupuncture is not medically necessary.

**Naprosyn 375mg, #60: 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 Medications for chronic pain; Anti-inflammatory medications Page(s): 60, 61; 22.

**Decision rationale:** This patient presents with right-sided low back pain that radiates into the right hip. The current request is for Naprosyn 375 mg #60. Regarding NSAIDs, the MTUS Guidelines page 22 supports its use for chronic low back pain, at least for short-term relief. This also supported for other chronic pain conditions. The medical file provided for review includes 1 progress report dated 09/17/2014 which list Naprosyn as the current medication. According to this report, the patient is currently utilizing Naprosyn and she reports that these medications are not effective enough to help with her pain. MTUS Guidelines page 60 requires recording of pain assessment and functional changes while medications are used for chronic pain. There is no adequate documentation of this medications efficacy and the patient has noted that this medication is not effective in reducing her pain. The requested Naprosyn is not medically necessary.