

<b>Case Number:</b>	CM15-0011863		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	03/07/2013
<b>Decision Date:</b>	03/20/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2015

### 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: Chiropractor, 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 a work/ industrial injury as a forklift driver and sustained a back injury while lifting boxes on 3/7/13. He has reported symptoms of burning and radicular lumbar pain with spasms. Pain was rated 5-6/10. Gait was antalgic, having pain with heel walking (greater on the left). The primary physician's progress report on 12/4/14 noted complaints of radicular pain with weakness of the left leg. Per the primary treating physician's progress report of 1/8/15, there was tenderness to palpation over the lower lumbar spine with paravertebral spasms and sciatic notch tenderness which demonstrated no changes from prior report. Prior medical history was negative. The diagnoses have included displacement lumbar intervertebral disc without myelopathy and thoracic/lumbosacral neuritis, radiculitis. Treatment to date has included conservative treatments, physical therapy, medication, and Transcutaneous Electrical Nerve Stimulation (TENS) unit. Mediations included Ketoprofen topical cream, Cyclobenzaprine cream, Synapryn, Tobradol, Deprizine, Diphenhydramine, and Fenatrex. Acupuncture was ordered for treatment. On 1/9/15, Utilization Review non-certified Acupuncture Treatment 3 x week x 6 weeks, noting the California Medical treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture Treatment 3x wek 6wks: Upheld**

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

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

**Decision rationale:** Patient has not had prior Acupuncture treatment. Provider requested initial trial of 3X6 acupuncture sessions which were modified to 6 by the utilization review. Per guidelines 3-6 treatments are supported for initial course of Acupuncture with evidence of functional improvement prior to consideration of additional care. Requested visits exceed the quantity of initial acupuncture visits supported by the cited guidelines. Additional visits may be rendered if the patient has documented objective functional improvement. MTUS- Definition 9792.20 (f) Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. Per guidelines and review of evidence, 18 Acupuncture visits are not medically necessary.