

<b>Case Number:</b>	CM14-0116190		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	03/05/2013
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2014

### 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 California. 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 50-year-old-male who sustained injury on 03/05/13. No mechanism of injury was mentioned. He complains of pain in the lower back and right shoulder. Pain was rated 8/10 in the right shoulder and 8/10 in the low back pain with radiation to left buttock. There was tenderness in the lumbar spine with myospasm, positive bilateral straight leg raise, decreased ROM. Sensation was noted decreased in the bilateral L4 and L5 dermatomes and motor strength was decreased in bilateral quadriceps and extensor hallucis longus. The MRI of the lumbar spine showed L4-5 disc protrusion with annular tear effacing the thecal sac. The examination of the shoulder has also showed tenderness to palpation over the right AC joint and subacromial region, with decreased ROM and positive impingement. He is status post right shoulder surgery. He started physical therapy and states that the pain is improving. Recommendation was lumbar epidural steroid injection and EMG of bilateral lower extremities, work conditioning, PT, and acupuncture. Medications include: Gabapentin, Naproxen, Omeprazole, Norco, Lisinopril and Metformin. The injured worker is noted that has had 37 PT visits for lower back and right shoulder. Diagnoses include low back pain, lumbar disc displacement with radiculopathy, Lumbar sprain / strain, shoulder rotator cuff syndrome and sprain/strain, and status post right shoulder arthroscopic rotator cuff repair. The previous UR determination for acupuncture 2x4 was modified to acupuncture 2x3, but no mention was made that the patient actually received acupuncture treatment. The request for physical therapy 2x4, and request for work conditioning 2x4 were denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture 2 x 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.1 California Code of Regulations, Title 8, under the Special Topics, Acupuncture Medical Treatment Guidelines.

**Decision rationale:** Acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. According to the treatment guidelines, acupuncture may be an option for patients when pain medication is reduced or not tolerated, which is not the case of this patient. If implemented, the guidelines state 3-6 treatments is sufficient time to produce results, and additional treatments may only be indicated with documented functional improvement. As such, the requested number of sessions is not supported by the guidelines. As such, this request is not medically necessary.

**Physical Therapy 2 x 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine, page 98 Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back pain.

**Decision rationale:** As per the CA MTUS guidelines, physical medicine is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines recommend up to 25 visits over 14 weeks for post-operative PT of the shoulder and 9-10 PT visits over 8 weeks for low back pain/strain and intervertebral disc disease. The patient had 37 PT visits; thus additional PT would exceed the guidelines recommendations. Furthermore, there is no documentation of any significant improvement in pain or function with prior therapy. Therefore, the request is considered not medically necessary.

**Work Conditioning 2 x 4:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Work Conditioning.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, page 125 Page(s): 125.

**Decision rationale:** Recommended as an option (10 visits over 8 weeks) with the following criteria: (1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level. (2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau. (3) Not a candidate where surgery or other treatments. (4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week. (5) A defined return to work goal agreed to by the employer & employee: (a) A documented specific job to return to with job demands that exceed abilities, OR (b) Documented on-the-job training (6) the worker must be able to benefit from the program. Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program. (7) The worker must be no more than 2 years past date of injury. (8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less. (9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities. In this case, the above criteria are not met. There is no documentation of plan for returning to work with complete job description. There is no documentation of medical recovery sufficient to allow for progressive activation and participation of 4 hours a day for 3-4 days a week. There is no mention of plateau in functional improvement. As such, the request is not medically necessary.