

<b>Case Number:</b>	CM15-0116374		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	09/07/2014
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	06/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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: 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 (IW) is a 54-year-old female who sustained an industrial injury on 09/07/2014. Diagnoses include lumbar spine strain with bilateral radiculitis; thoracic strain and resolved left hand strain. Treatment to date has included medications, back support, bracing, activity modifications, cold application and physical therapy. According to the Primary Treating Physician's Initial Comprehensive Report dated 11/4/14, the IW reported constant slight stiffness, soreness and pain in the low back. The pain radiated intermittently to the mid- and upper back and to the bilateral lower extremities and feet at times. Her pain was rated 3-8/10. She also complained of pain in the in the left buttock. She denied any symptoms in the left hand and thumb. On examination, posture was normal, hips were level and there were no deformities of the mid to lower spine. The paravertebral muscles from T6 to T12 were tender to palpation bilaterally, as were the left lumbar paravertebral muscles at L3. Range of motion was reduced in the thoracic and lumbar spine. Preliminary reading of the lumbar spine x-rays on 9/10/14 showed normal results; thoracic x-rays were positive for arthritic changes. A request was made for physical therapy twice weekly for three weeks for the thoracic and lumbar spine; and acupuncture twice weekly for three weeks for the thoracic and lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 3 weeks of the lumbar and thoracic spine:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy 2 times a week for 3 weeks of the lumbar and thoracic spine is not medically necessary and appropriate.

**Acupuncture 2 times a week for 3 weeks of the lumbar and thoracic spine:** Upheld

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

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

**Decision rationale:** It is not clear if the patient has participated in previous acupuncture. Current clinical exam show no specific physical impairments or clear dermatomal/myotomal neurological deficits to support for treatment with acupuncture to the spine. The patient has been certified physical therapy without documented functional improvement. There are no clear specific documented goals or objective measures to identify for improvement with a functional restoration approach for this injury with ongoing unchanged chronic pain complaints. MTUS, Acupuncture Guidelines recommend initial trial of conjunctive acupuncture visit of 3 to 6 treatment with further consideration upon evidence of objective functional improvement. Submitted reports have not demonstrated the medical indication to support this request or specific conjunctive therapy towards a functional restoration approach for acupuncture visits, beyond guidelines criteria for initial trial. The Acupuncture 2 times a week for 3 weeks of the lumbar and thoracic spine is not medically necessary and appropriate.