

<b>Case Number:</b>	CM13-0042953		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	03/17/2013
<b>Decision Date:</b>	02/21/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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 physician 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 patient is a 35-year-old female who reported an injury on 04/07/2011 due to cumulative trauma while performing normal job duties. The patient developed lateral epicondylitis of the right elbow and a trigger finger. Previous treatments have included anti-inflammatory drugs, physical therapy, and ergonomic modifications to the patient's work station, activity modification, and corticosteroid injections. The patient's most recent clinical evaluation revealed tenderness to palpation over the lateral epicondyle with a negative Cozen's maneuver and muscle tenderness of the right wrist and forearm. The patient's diagnoses included right elbow lateral epicondylitis, right forearm strain/intersection syndrome. The patient's treatment plan included continuation of medications, and continued physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture 2-3 x per week qty 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 requested acupuncture 2 to 3 times per week for 6 weeks is not medically necessary or appropriate. The clinical documentation submitted for review does not

provide any evidence that the patient has previously received this type of treatment. California Medical Treatment Utilization Schedule does recommend the use of acupuncture as an adjunct treatment to an active therapy program. There are no exceptional factors noted with the documentation to support extending treatment beyond guideline recommendations. As such, the requested acupuncture 2 to 3 times per week for 6 weeks is not medically necessary or appropriate.

**Kinetic activity qty 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The requested kinetic activity is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has previously participated in physical therapy. California Medical Treatment Utilization Schedule recommends that patients be transitioned into a home exercise program to maintain improvements obtained during supervised skilled therapy. The clinical documentation does not provide any barriers that would preclude self management of kinetic activity as part of an independent home exercise program. Additionally, the clinical documentation submitted for review does not provide any evidence of how the requested activity will contribute to the patient's functional restoration. As such, the requested kinetic activity is not medically necessary or appropriate.

**Refer to pain management qty 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM); Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2nd Edition (2004), page 18

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM ), 2nd Edition, (2004) Chapter 6, page 163

**Decision rationale:** The requested referral to pain management is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends referrals to specialty consultations when additional expertise is needed to assist with treatment planning or if the treating physician feels the patient would benefit from treatment that must be provided outside their scope of practice. The clinical documentation submitted for review does not provide any evidence that the patient would benefit from treatments outside the scope of practice of the treating physician. The clinical documentation does not address the need for

assistance from a specialist to develop a treatment plan for the patient. As such, the request for referral to pain management, quantity 1 is not medically necessary or appropriate.