

<b>Case Number:</b>	CM15-0146203		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	01/19/2014
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	07/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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, Pain Management

### 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 year old female who sustained an industrial injury on 1-19-14. She had complaints of low back, left hip, bilateral hand, and bilateral wrist pain. Diagnostic studies include: x-ray, MRI and EMG-NCV. Treatments include: medication, physical therapy, TENS unit, acupuncture, chiropractic and injections. Progress report dated 4-1-15 reports continued complaints of neck, bilateral shoulder, bilateral hands, bilateral wrists, left hip and low back pain. The neck pain is constant and radiates down both arms to the hands, the left side more than the right. She has occasional numbness and tingling across the bilateral upper extremities to forearms down the both hands. Bilateral shoulder pain increases with overhead movement and backward activities, pushing, pulling, lifting, and prolonged sitting and standing. Bilateral hand pain is frequent moderate to severe with numbness and tingling. Bilateral wrist pain is frequent moderate to severe pain with soreness and stiffness. Low back pain is constant moderate to severe, left side greater than the right. Stated left hip pain is actually in the sacroiliac area and radiates from the lumbar spine. The pain in all areas is rated 5 out of 10 at best and 9 out of 10 at its worst. Diagnoses include: cervicothoracic spine sprain, rule out left C7-8 radiculopathy, bilateral shoulder sprain, left elbow medial epicondylitis, rule out ulnar canal syndrome, bilateral wrist sprain with left carpal tunnel syndrome and bilateral de quervain's, lumbar spine sprain with left sciatic, rule out radiculopathy and left hip pain. Plan of care includes: hold on medication until psychologically more stable, request psychological evaluation, request functional capacity evaluation and urine drug test, prescribed cyclobenzaprine-Tramadol topical

cream and ibuprofen cream, request replacement of TENS unit. Work status: temporarily totally disabled. Follow up in 6 weeks.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Physical therapy cervical/bilateral shoulders- 12 visits:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Shoulder Chapters, Physical Medicine.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

**Physical therapy lumbar- 12 visits:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Medicine.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that

cannot be addressed within the context of an independent home exercise program yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

**Acupuncture- 12 visits:** Upheld

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

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

**Decision rationale:** Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions" and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it appears the patient has undergone acupuncture previously, but there is no documentation of objective functional improvement from the therapy already provided. As such, the currently requested acupuncture is not medically necessary.