

<b>Case Number:</b>	CM15-0199188		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	06/28/2011
<b>Decision Date:</b>	11/23/2015	<b>UR Denial Date:</b>	09/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 62 year old male, who sustained an industrial injury on June 28, 2011. He reported low back pain. The injured worker was currently diagnosed as having cervical thoracic and lumbar strain and right knee degenerative arthritis possible internal derangement. Treatment included diagnostic studies, physical therapy, chiropractic treatment, acupuncture, knee support, knee surgery, cognitive behavioral therapy, medications and exercises. On July 20, 2015, the injured worker reported low back pain into the left buttock and thigh. Physical examination of the lumbar spine showed tenderness at L4-5. The treatment plan included physical therapy and traction therapy for the lumbar spine, functional orthotics to improve weight bearing tolerance and physical therapy for the right knee. On August 31, 2015, the injured worker complained of persistent right knee pain and clicking with side to side movements and extension. He also reported occasional weakness of the right knee. Physical examination of the right knee revealed trace swelling. Range of motion was 0-115 degrees with positive lateral patella tracking and slightly increased anterior drawer. Acupuncture treatment was noted to help him in the past. His hinged knee support was noted to be helping him with swimming exercise. He was doing his physical therapy as authorized. The treatment plan included additional physical therapy visits for the right knee, acupuncture, a new hinged knee support and Glucosamine-Chondroitin. On September 25, 2015, utilization review denied a request for physical therapy and traction therapy two times a week for four weeks for the lumbar spine, acupuncture two times a week for four weeks for the right knee, additional physical therapy two times a week for four weeks for the lumbar spine and hinged right knee brace.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Physical therapy and traction therapy 2 times a week for 4 weeks for the lumbar spine:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Traction.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Traction.

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per the ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. The ODG states that traction is not recommended using powered traction devices, but home-based patient controlled gravity traction may be a non-invasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. According to the records, this patient has had previous physical therapy sessions and there is no documentation indicating that he had a defined functional improvement in her condition. There is no specific indication for the additional physical therapy sessions requested (2/ week x 4 weeks for the lumbar spine) and traction. Medical necessity for the additional PT visits requested has not been established. The requested services are not medically necessary.

### **Acupuncture 2 times a week for 4 weeks for the right knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** According to the Acupuncture Medical Treatment Guidelines, 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 recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented, as defined by the guidelines further treatment will be considered. In this case, there is documentation of previous acupuncture visits; however, there is no documentation of objective functional improvement with previous treatments. Medical necessity for acupuncture (2/week x 4 weeks for the right knee) has not been established. The requested service is not medically necessary.

**Additional physical therapy 2 times a week for 4 weeks for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per the ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient has had previous physical therapy sessions and there is no documentation indicating that he had a defined functional improvement in her condition. There is no specific indication for the additional PT sessions requested (2/week x 4 weeks for the lumbar spine). Medical necessity for the additional PT visits requested has not been established. The requested services are not medically necessary.

**Hinged right knee brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter, Unloader braces for the knee.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee.

**Decision rationale:** According to the ODG, a knee brace is indicated if there is evidence of knee instability. There is evidence of right knee instability documented on physical exam. In this case, the patient already has a hinged knee brace. There is no specific indication for another hinged knee brace Medical necessity for the requested item has not been established. The requested right knee hinged brace is not medically necessary.