

<b>Case Number:</b>	CM15-0020678		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	08/16/2013
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2015

### 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 is a 29 year old female, who sustained an industrial injury on August 16, 2013. She has reported a wrist injury from repetitive use. The diagnoses have included cervicgia, neck pain, carpal tunnel syndrome, elbow tendinitis, and low back pain. Treatment to date has included physical therapy, acupuncture, and medications. Currently, the injured worker complains of neck and upper back pain, intermittent bilateral wrist pain, with tingling and numbness in the right hand, and bilateral arm pain. The Treating Physician's report dated January 22, 2015, noted pain with palpation at the right lateral epicondyle aspect, with positive Tinel's and Phalen's, mild on the right wrist. An electrodiagnostic study was noted to show no evidence of peripheral neuropathy or cervical radiculopathy. On January 29, 2015, Utilization Review non-certified acupuncture 2x6 sessions and physical therapy 3x4 sessions, noting there were no objective findings to support the medical necessity of additional acupuncture and physical therapy. The MTUS Acupuncture Medical Treatment Guidelines, the MTUS Chronic Pain Medical Treatment Guidelines, the MTUS American College of Occupational and Environmental Medicine Guidelines (ACOEM), and the Official Disability Guidelines (ODG) were cited. On February 4, 2015, the injured worker submitted an application for IMR for review of certified acupuncture 2x6 sessions and physical therapy 3x4 sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **Acupuncture 2 x 6:** Upheld

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

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

**Decision rationale:** MTUS, Acupuncture Guidelines recommend initial trial of conjunctive acupuncture visit of 3 to 6 treatment with further consideration upon evidence of objective functional improvement. Review indicated the patient has received prior sessions of acupuncture; however, submitted reports have not clearly demonstrated any functional benefit or pain relief derived from prior treatment and have not demonstrated medical indication to support for additional acupuncture sessions. The previous provider also had discontinued acupuncture noting lack of relief. There are no specific objective changes in clinical findings, no report of acute flare-up or new injuries, nor is there any decrease in medication usage from conservative treatments already rendered. The Acupuncture 2 x 6 is not medically necessary and appropriate.

### **Physical therapy 3 x 4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**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 9-10 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 3 x 4 is not medically necessary and appropriate.

