

<b>Case Number:</b>	CM15-0060893		
<b>Date Assigned:</b>	04/07/2015	<b>Date of Injury:</b>	09/15/2009
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/31/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 44 year old female, who sustained an industrial injury on September 15, 2009. She reported cumulative trauma and repetitive strain while working as an office coordinator. The injured worker was diagnosed as having right shoulder pain, cervical facet syndrome, cervical strain, right wrist pain, right elbow pain, low back pain, bilateral sacroiliac pain, lumbar facet syndrome, right medial epicondylitis, and right lateral epicondylitis. Treatment to date has included cervical spine/right shoulder MRIs, electromyography (EMG)/nerve conduction velocity (NCV), physical therapy, steroid joint injections, and medication. Currently, the injured worker complains of increased neck pain, constant pain in the right lateral shoulder, and pain in the neck, right lateral trapezius muscle, right lateral elbow, mid line lumbar back, and medial aspect of the cervical spine, with referred pain down to the posterior legs and calf. The Primary Treating Physician's report dated January 16, 2015, noted the injured worker had received a cervical facet medial branch block on the right side at C4, C5, and C6 on January 7, 2015, feeling pain relief for six hours, feeling 80% better after procedure and would like to proceed with radiofrequency. Current medications were listed as Celebrex, Skelaxin, Gabapentin, and Seroquel. The cervical spine examination revealed tenderness to palpation over the posterolateral cervical paravertebral musculature and medial superior trapezius muscles, with positive facet loading pain, and pain with cervical extension and end-range rotation. Bilateral elbow examination was noted to show tenderness to palpation over the right medial and right lateral epicondyle, pain with wrist flexion resistance referring to the right medial epicondyle. The bilateral wrists examination was noted to show tenderness to palpation

over the ulnar wrists, anteroposterior compression and mediolateral compression, noted pain to the right wrist with ulnar deviation and radial deviation end ranges, with Tinel's sign positive to the right and negative to the left. Examination of the lumbar spine revealed tenderness to palpation over the paramedian lumbar paravertebral musculature, pain with lumbar extension and positive lumbar facet loading maneuver, and positive Patrick (Faber) test positive bilaterally. The treatment plan was noted to include a request for right side cervical C4, C5, and C6 radio-frequency, appeal denial of a lumbar medial branch blocks at the bilateral L4-L5 and L5-S1 levels, and physical therapy approved for six sessions for instructions of a home exercise program (HEP).

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

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

**6 physical therapy 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 physical medicine Page(s): 98-99.

**Decision rationale:** The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-

10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy. There is no explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. In the absence of such documentation, the request is not medically necessary.