

<b>Case Number:</b>	CM15-0127745		
<b>Date Assigned:</b>	07/14/2015	<b>Date of Injury:</b>	04/16/2002
<b>Decision Date:</b>	08/10/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/01/2015

### 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: Preventive Medicine, Occupational Medicine

### 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 63 year old female who sustained an industrial injury on 4/16/2002. The injured worker was diagnosed as having musculoligamentous sprain of the lumbar and cervical spine, internal derangement of the right knee, right upper extremity overuse syndrome, right wrist carpal tunnel syndrome and right elbow lateral epicondylitis. The patient is not working (retired). There is no record of a recent diagnostic study. Treatment to date has included acupuncture, physical therapy, knee splint and medication management. In a progress note dated 5/19/2015, the injured worker complained of neck pain, low back pain, right knee pain and swelling, right wrist pain and right elbow pain. Physical examination showed antalgic gait, right elbow tenderness, moderate joint effusion on the right knee with decreased range of motion and decreased cervical range of motion. The treating physician is requesting transportation to and from appointments, 12 sessions of physical therapy and acupuncture visits-2-3x a week for 3 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transportation to and from Doctors' appointments:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Transportation (to & from appointments).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 177; 266, 268; 32; 298, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (acute and chronic).

**Decision rationale:** Providing transportation to and from medical appointments is not addressed by the MTUS other than the recommendation by the ACOEM guidelines for measures to be taken to avoid activities which will aggravate the patient's signs and symptoms. The Official Disability Guidelines supports use to transportation to and from medical appointments but only when the patient has a diagnosed disability that prevents self-transport. There is no documentation of a diagnosed disability nor a description of signs or symptoms of a disability that would preclude self transport to medical appointments. Medical necessity for providing transportation to and from medical appointments has not been established. The request is not medically necessary.

**Physical therapy; twelve (12) sessions (1x12): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 48-9; 90; 173-5, 181-2; 15, 20-2; 257-60, 264-6, 270-1; 299-301, 308-9, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-9.

**Decision rationale:** Physical therapy or physiotherapy (often abbreviated to PT) is a form of medical therapy that remediates musculoskeletal impairments and promotes mobility, function, and quality of life through the use of mechanical force and movement (active and passive). Passive therapy may be effective in the first few weeks after an injury but has not been shown to be effective after the period of the initial injury. Active therapy directed towards specific goals, done both in the Physical Therapist's office and at home is more likely to result in a return to functional activities. This treatment has been shown to be effective in restoring flexibility, strength, endurance, function, range of motion and can alleviate discomfort. But, to be effective, active therapy requires an internal effort by the patient to complete the specific exercises at the PT clinic and at home. According to the MTUS, goal directed physical therapy for low back pain should show a resultant benefit by 10 sessions over a 4 week period and the program should be tailored to allow for fading of treatment. The ACOEM guidelines additionally recommends that physical therapy for patients with delayed recovery be time contingent. This patient has chronic musculoskeletal conditions that has required physical therapy in the past and may require

repeat PT treatments for exacerbation of pain. Although repeat physical therapy is effective for exacerbations of chronic musculoskeletal conditions the therapy should follow the above recommendations and a good home exercise program is key to prevent recurrent flare-ups. The prior PT established a home exercise program. Since the patient is not experiencing an exacerbation of her pain, extending her present PT beyond the above MTUS guidelines without giving good cause is not indicated at this point in this patient's care. Medical necessity for physical therapy has not been established. The request is not medically necessary.

**Acupuncture; 2-3 times per week for 3 months:** Upheld

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

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

**Decision rationale:** Acupuncture is a technique to control and improve pain control in patients with acute and chronic pain. It is thought to allow or cause endorphin release that subsequently causes pain relief, reduction of inflammation, analgesia, increased blood circulation and muscle relaxation. The MTUS guidelines for continued use of this therapeutic modality requires documentation of functional improvement from this therapy. Note: functional improvement is defined by the MTUS as clinically significant improvement in activities of daily living or a reduction in work restrictions. Review of the available medical records does not document a functional improvement from acupuncture despite use of this procedure for over 6 months. Continued use of this treatment modality in this patient is not indicated at this time. Medical necessity has not been established. The request is not medically necessary.