

<b>Case Number:</b>	CM15-0176991		
<b>Date Assigned:</b>	09/17/2015	<b>Date of Injury:</b>	03/05/2014
<b>Decision Date:</b>	10/20/2015	<b>UR Denial Date:</b>	08/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2015

### 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 50 year old female, who sustained an industrial injury on 3-5-14. The documentation on 8-4-15 noted that the injured worker has complaints of pain in her cervical spine, lumbar spine and headaches. The injured worker continues to have memory loss as well as headaches. The documentation noted that the injured workers left knee symptoms have worsened and she has a moderate amount of effusion at the left knee. Cervical spine examination revealed tenderness to palpation of the paraspinal muscles. Range of motion flexion, extension, right rotation was 50 out of 65 and left rotation and left lateral bending was 60 out of 65 and right lateral bending was 55 out of 65. Lumbar spine examination revealed tenderness to palpation of the paraspinal muscles and spasms are present in the paraspinal muscles. Range of motion right rotation, left rotation, right lateral bending, left lateral bending, extension and flexion was 20 out of 30. The diagnoses have included brachial neuritis or radiculitis not otherwise specified and thoracic or lumbosacral neuritis or radiculitis, unspecified. Treatment to date has included butalbital, acetaminophen, caffeine medications. The original utilization review (8-14-15) non-certified the request for physical therapy, three times a week, for four weeks to the cervical and left knee and magnetic resonance imaging (MRI) of the left knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy, three times a week, for four weeks to the cervical and left knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**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. There is no objective explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. The request is not medically necessary.

**MRI of the left knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The ACOEM chapter on knee complaints states: Most knee problems improve quickly once any red-flag issues are ruled out. For patients with significant hemarthrosis and a history of acute trauma, radiography is indicated to evaluate for fracture. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. Even so, remember that while experienced examiners usually can diagnose an ACL tear in the non-acute stage based on history and physical examination, these injuries are commonly missed or over-diagnosed by inexperienced examiners, making MRIs valuable in such cases. Also note that MRIs are superior to arthrography for both diagnosis and safety reasons. Table 13-5 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. The physical exam does not show positive signs of serious knee pathology that would require imaging. The patient has an effusion and increased pain only. Therefore the request is not medically necessary.