

Case Number:	CM13-0062467		
Date Assigned:	12/30/2013	Date of Injury:	09/28/2012
Decision Date:	04/07/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/06/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and Pain Medicine, and is licensed to practice in Texas and Ohio. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 35-year-old female who reported an injury on 09/28/2012. The mechanism of injury information was not provided in the medical record. Review of the medical record reveals the patient's diagnosis includes complex regional pain syndrome of the left upper extremity. Clinical letter dated 01/10/2014 revealed the patient's range of motion was at -20 degrees of full flexion of the elbow, which is a gain of 10 degrees. The patient had been using select physical therapy, and her most recent note from 01/06/2014 showed the extension of the elbow to be -20 degrees on 12/23/2013. Physical therapy progress note dated 01/06/2014 revealed the patient stated she can now fold laundry, carry light weight objects, and lift light weight objects. The patient was making good progress with therapy treatment. She exhibited slight limitation with elbow extension with active range of motion, but has full passive range of motion. The range of motion to the left hand, wrist, forearm, and shoulder were all within normal limits. The patient demonstrated improving pain and function. She is now able to grip 5 pounds and pinch 7 pounds. The patient is able to carry 2 pounds and reach overhead. The patient's 9-hole coordination test is now equal to the contralateral hand. She continues to have pain but is managing better.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 3 TIMES PER WEEK FOR THE LEFT UPPER EXTREMITY:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Physical Medicine Page(s): 98-99.

Decision rationale: The MTUS Guidelines identify the best practice for physical therapy guidelines for reflex sympathetic dystrophy or complex regional pain syndrome is that which allows for fading of treatment frequencies from up to 3 visits a week to 1 or less, plus active self-directed home exercise and physical therapy program in 24 visits over 16 weeks. It is noted in the progress note dated 01/06/2014 that the employee has made good progress with therapy treatment. The employee is exhibiting range of motion within normal limits to the left hand, wrist, forearm, and shoulder. The employee has slight limitation with elbow extension with active range of motion, but full passive range of motion. The employee has been educated in a home exercise program and has been participating in such a program. The employee has received 54 physical therapy visits to date, according to the progress note dated 01/06/2014. At this time, it is expected that the employee will be able to independently participate in a home exercise program for continued management of the condition. As such, the medical necessity for the requested service cannot be determined at this time. The request for physical therapy 3 times per week for the left upper extremity is non-certified.

SPINAL CORD STIMULATOR TRIAL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Spinal cord stimulators (SCS) Page(s): 106-107.

Decision rationale: According to the MTUS Guidelines, it is indicated that the use of spinal cord stimulators are recommended only for selected patients in cases where less invasive procedures have failed or are contraindicated for specific conditions indicated. There is documentation that the employee's most recent physical therapy has in fact helped the employee, and has made good progress according to the clinical note dated 01/06/2014. The employee's response to physical therapy, the increased functional capabilities, and decrease in pain does not suggest failed conservative treatment. Therefore, the medical necessity for the requested service cannot be determined at this time. The request for spinal cord stimulator trial is non-certified.