

<b>Case Number:</b>	CM13-0063981		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	08/12/2008
<b>Decision Date:</b>	03/31/2014	<b>UR Denial Date:</b>	12/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/11/2013

### 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 and Rehabilitation and is licensed to practice in California. 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:

This 64 year-old female patient sustained an injury on 8/12/08 while employed by [REDACTED]. Requests under consideration include Consult for Physical Medicine & Rehabilitation and Physical Therapy x 6. Report of 12/16/13 from provider noted patient continued with moderate dull achy pain at right arm and wrist, increased with lifting and decreased with rest. The patient denied radiation and denied numbness, weakness, or paresthesias. She uses Ibuprofen as needed and has not started therapy yet. Exam noted well-developed, well-nourished, and in no distress appearance; right shoulder has decreased range of motion (no plane identified), tenderness without swelling, effusion, crepitus, deformity, spasm with normal pulse and strength; right wrist has normal range, no tenderness, no swelling, no effusion, no crepitus, and no deformity. Diagnosis was Complex Regional Pain Syndrome. Treatment plan included physical therapy, Ibuprofen, and physical medicine and rehab consultation. The above requests for PT and PMR consultation were non-certified noting lack of clinical presentation to support for consultation or further therapy citing guidelines criteria.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**The request for Consult Physical Medicine & Rehabilitation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Section on Specialists/Consultants, Pages 115, 127

**Decision rationale:** The guidelines states an occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, however, that has not been shown here as clinical exam only noted nonspecific decreased range of right shoulder without any defining significant clinical findings correlating to acute red-flag conditions. In this case, the medical exam noted well-developed, well-nourished, and in no distress appearance; right shoulder has decreased range of motion (no plane identified), tenderness without swelling, effusion, crepitus, deformity, spasm with normal pulse and strength; right wrist has normal range, no tenderness, no swelling, no effusion, no crepitus, and no deformity. Diagnosis was Complex Regional Pain Syndrome. Treatment plan included physical therapy, Ibuprofen, and physical medicine and rehab consultation. Submitted reports have not adequately demonstrated any symptoms or clinical findings consistent with CRPS, necessitating a PMR consultation for this chronic 2008 injury. The request for Consult Physical Medicine & Rehabilitation is not medically necessary and appropriate.

**The request for Physical Therapy x6:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy. 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. There are unchanged chronic symptom complaints and clinical findings. 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. The employee has failed conservative treatment without physiologic evidence of tissue insult, neurological compromise, or red-flag findings to support treatment request. The Physical Therapy x 6 is not medically necessary and appropriate.