

<b>Case Number:</b>	CM14-0173357		
<b>Date Assigned:</b>	10/24/2014	<b>Date of Injury:</b>	07/23/2014
<b>Decision Date:</b>	12/22/2014	<b>UR Denial Date:</b>	09/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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. The expert reviewer is Board Certified in Internal Medicine 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 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/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:

Pursuant to a progress note dated August 20, 2014, the injured worker complains of burning and tingling sensation in the left forearm. The pain is rated 4-8/10. The injured worker had 6 sessions of physical therapy, which did not help relieve the pain. He is treating the pain with ice and NSAIDs. Objective physical findings revealed pain to extension of the wrist. There was no erythema or ecchymosis at forearm. The provider is recommending continuation of physical therapy, 2 times a week for 3 week for limited range of motion, decreased strength, functional deficits and clinically relevant pain. There was no objective improvement from physical therapy that was documented. There was no documentation as to why the injured worker is not able to continue with rehabilitation on a home exercise program basis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, 2 times 3 for the left elbow/wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy Page(s): 474.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Physical Therapy

**Decision rationale:** Pursuant to the Official Disability Guidelines, physical therapy two times a week for three weeks to the left elbow/wrist is not medically necessary. The guidelines provide physical therapy frequency and duration. General guidelines allow up to three visits contingent upon objective improvement documented in the record. Further trial visits with fading frequency up to six contingents on further objectification of long-term resolution of symptoms, plus active self-directed home physical therapy. In this case, the injured worker is a 46-year-old man. The July 24, 2014 progress note showed left forearm tenderness to palpation with pain to flexion and extension resistance. He is wearing a strap but it is not helping. The injured worker admits to having prior physical therapy which did not help or relieve his pain in a significant fashion. There was mild subjective improvement but objective benefits were not documented in the medical record (as a result of physical therapy). There was no documentation in the medical record indicating why the injured worker could not continue on a home exercise program. The injured worker did not meet the criteria for continued physical therapy (see ODG). Consequently, physical therapy two times a week for three weeks to the left elbow/wrist is not medically necessary.