

<b>Case Number:</b>	CM14-0026579		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	10/22/2002
<b>Decision Date:</b>	07/31/2014	<b>UR Denial Date:</b>	02/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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 Orthopedic Surgery 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:

The injured worker is a 57-year-old female who reported an injury on 10/22/2002 due to an unknown mechanism of injury. The injured worker complained of neck pain rated 7/10 with radiation to the hands bilaterally. She also complained of low back pain rated 7/10 with radiation to the bilateral lower extremities. The pain was described as a burning sensation. She also had right ankle and right foot cramping. She reports feelings of depression, stress, and insomnia. On 01/31/2014, the physical examination revealed a positive straight leg raise, Braggart's test, and Patrick FABERE test. She had restricted range of motion to the lumbar spine, right hip, and bilateral ankles. There were no diagnostic studies submitted for review. The past treatment included physical therapy. The injured worker was using a topical cream containing gabapentin 10%, cyclobenzaprine 10%, and capsaicin 0.0375% (120 gm). The current treatment plan is for physical therapy for the bilateral wrists, hands, and forearms, lumbar spine, and right hip 2 times a week for 4 weeks. The rationale was not submitted for review. The request for authorization form was dated 01/31/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy (PT) for the Bilateral Wrists, Hands and Forearms, Lumbar Spine and Right Hip-Two Times a Week for Four Weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine chapter Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine chapter Page(s): 99.

**Decision rationale:** The request for PT for the bilateral wrists, hands, and forearms, lumbar spine, and right hip 2 times a week for 4 weeks is not medically necessary. The CA MTUS guidelines state in regards to physical therapy to allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The injured worker has received physical therapy prior to the request date. There was lack of documentation of functional improvements. In addition, the request exceeds the recommended number of therapy sessions per the guidelines. Given the above, the request for PT for the bilateral wrists, hands, and forearms, lumbar spine, and right hip 2 times a week for 4 weeks is not medically necessary.