

<b>Case Number:</b>	CM14-0046269		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	06/28/2010
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	04/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 Occupational 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:

The claimant was injured on 06/28/10. Physical therapy for 16 visits is under review. She has diagnoses of carpal tunnel syndrome, left cubital tunnel syndrome, and causalgia. She has attended physical therapy for her conditions. She had a QME on 10/17/13. She underwent left carpal tunnel release on 11/24/10 but her symptoms continued and worsened. She also was diagnosed with a left shoulder strain and rotator cuff syndrome and had a subacromial injection in January 2011. She was diagnosed with neuropathic pain and type I complex regional pain syndrome in 02/11 by [REDACTED]. Medications, stellate ganglion blocks and physical therapy were recommended. She had multiple other problems and also became dependent on narcotics. On 01/02/14, she was evaluated for upper extremity pain. She had completed physical therapy and chiropractic. Physical therapy did not help her pain. 16 physical therapy visits were recommended for desensitization along with 12 sessions with a pain psychologist. Stellate ganglion blocks were under consideration if the PT did not help. As of 01/29/14, PT was still pending. On 02/26/14, a provider's noted states that physical therapy was helping but the PT was asking about nerve conduction testing because of muscle wasting in the left trapezius. She saw the pain psychologist. On 03/26/14, she stated that the PT was not working on her hand because it was not part of the order. This was rectified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY X 16:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine treatment Page(s): 130.

**Decision rationale:** The history and documentation do not objectively support the request for an additional 16 visits of PT. The claimant has attended what should have been a reasonable number of PT visits and there is no objective clinical information that indicates that she has been receiving significant benefit along with evidence of functional improvement with this treatment. There is no evidence that warrants the continuation of PT for an extended period of time or any indication that the claimant remains unable to complete her rehab with an independent HEP. The MTUS state "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 - Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks." The claimant did not receive benefit from PT in the past and it is not clearly described why this PT is expected to provide significant pain relief or objective and measurable improvement. The medical necessity of the additional therapy has not been clearly demonstrated. Therefore, the request is not medically necessary.