

<b>Case Number:</b>	CM14-0066476		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	10/19/2011
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	04/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/09/2014

### 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:

There were 40 pages provided for this review. The application for independent medical review was signed on May 9, 2014. The requested medical services, goods or items that were denied or modified was additional physical therapy two times a week for six weeks for the neck, trapezius and thoracic outlet syndrome. Per the records provided, treatment to date has included Botox injections for cervical dystonia and thoracic outlet syndrome on April 2, 2014 and prior therapy of 20 sessions of physical therapy, eight occupational therapy sessions in 18 chiropractic visits. No red flags or progressive deficits were noted. The diagnoses included right carpal tunnel syndrome, thoracic outlet syndrome and cervical degenerative disc disease. The status of the independent exercise program is not addressed. There is no mention of comorbidities or complications or extenuating clinical circumstances. The diagnoses as of September 17, 2013 were cervical sprain, rule out cervical radiculopathy, lateral epicondylitis and carpal tunnel syndrome. She is capable of returning to work. She continues to remain off work. She underwent cortisone injections in the right and left wrist. As of May 18, 2013 she said her hands got so bad she couldn't even open the hands. She also has neck pain. There is pain in the right elbow into the left elbow.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy for cervical, traps and thoracic outlet syndrome, twice weekly for six weeks:** Upheld

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

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

**Decision rationale:** The patient has had extensive amounts of therapy. The MTUS does permit physical therapy in chronic situations, noting that one should 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 conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: 1. Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient...Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. 2. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. Therefore, the request for additional physical therapy for cervical, traps and thoracic outlet syndrome, twice weekly for six weeks, is not medically necessary or appropriate.