

<b>Case Number:</b>	CM14-0196645		
<b>Date Assigned:</b>	12/04/2014	<b>Date of Injury:</b>	06/20/2011
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: California, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 69 year old female who sustained an industrial injury on 06/20/11. Initial complaints and diagnoses are not available. Treatments to date include medications, work restrictions, home exercises, and a TENS unit. Diagnostic studies include MRI of the bilateral wrists and neck, x-rays of the bilateral wrists and right elbow, a nerve conduction study, and a Functional Capacity Evaluation. Current complaints include neck, upper and middle back, bilateral elbow, and right wrist pain. In a progress note dated 09/26/14 the treating provider reports the plan of care as methocabanol as a replacement for Tizanidine. The requested treatment is physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy Neck/back/wrist 3 times a week for 4 weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines

(ODG) Neck Section, Low Back Section, and Forearm, Wrist and Hand Section - Physical Therapy.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy neck/back/wrist three times per week times four weeks is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured workers working diagnosis are musculoligamentous sprain cervical spine; radiculopathy cervical; anxiety; chronic pain and disability with delayed functional recovery; cubital tunnel syndrome wrist; cubital tunnel syndrome elbow; wrist derangement right; medial epicondylitis bilateral; lateral epicondylitis elbow bilateral; tendon-ligamentous injury bilateral lateral elbows and wrists. The documentation is unclear as to the quantity of physical therapy and location of physical therapy rendered to the injured worker. The documentation states "no new forms of therapy" were rendered. The date of injury is June 20, 2011. The treatment plan states the injured worker is engaged in a home exercise program. The guidelines recommend: "When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." There are no compelling clinical facts or documentation in the medical record indicating additional physical therapy is clinically warranted. There is no documentation of prior physical therapy notes or objective functional improvement. In the alternative, if the injured worker has not received prior physical therapy to date, the treating provider exceeded the recommended guidelines in requesting 12 sessions. Patients should be formally assessed after a six visit clinical trial to see if the patient was moving in a positive direction, no direction or negative direction prior to continuing with physical therapy. The provider requested 12 sessions in excess of the recommended guidelines. Consequently, absent compelling clinical documentation with objective(s) improvement referencing prior physical therapy to date with the total number of sessions to date (or in the alternative requesting 12 initial sessions of physical therapy if none was rendered to date), physical therapy neck/back/wrist three times per week times four weeks is not medically necessary.