

<b>Case Number:</b>	CM14-0219361		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	04/19/2004
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 46 year old female, who sustained an industrial injury on 04/19/2004. She had reported right wrist pain. The diagnoses have included complex regional pain syndrome. Treatment to date has included Transcutaneous Electrical Nerve Stimulation Unit, wrist brace, and medications. No diagnostics testing results were included in received medical records. Currently, the IW complains of chronic intractable right upper extremity pain. The physician stated on a primary treating physician's progress report dated 05/07/2014 they were waiting for authorization for acupuncture therapy. On 11/26/2014, the injured worker submitted an application for IMR for review of Physical Therapy. On 12/05/2014, Utilization Review non-certified the above request. The MTUS, ACOEM Guidelines, (or ODG) was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy (PT):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

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

**Decision rationale:** The patient presents with wrist pain and hand pain. The request is for PHYSICAL THERAPY. Neither any of the progress reports provided nor the utilization review letter indicate how many total sessions of therapy the treater is requesting for. The report with the request is not provided. MTUS page 98 and 99 has the following: Physical Medicine: Recommended as indicated below. Allow for fading of treatment frequency from up to 3 visits per week to one or less, plus active self-directed home physical medicine. MTUS Guidelines page 98 and 99 states that for myalgia, myositis, 9 to 10 sessions are recommended over 8 weeks, and for myalgia, neuritis, and radiculitis, 8 to 10 visits are recommended. MTUS Chronic Pain Medical Treatment Guidelines, Physical Medicine section, pages 98-99 states 24 visits over 16 weeks are appropriate for Reflex sympathetic dystrophy/ CRPSThere is not enough information provided to confirm that the physical therapy is provided in accordance with MTUS guidelines. The requested duration and frequency of the physical therapy is not known. MTUS guidelines for physical therapy are based on the number of physical therapy sessions. Without specifying the total number of sessions, or duration and frequency of therapy, the request cannot be verified to be in accordance with MTUS guidelines.