

<b>Case Number:</b>	CM15-0131618		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	03/21/2014
<b>Decision Date:</b>	08/13/2015	<b>UR Denial Date:</b>	06/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2015

### 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, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 55 year old female sustained an industrial injury on 3/21/14. She subsequently reported pain in the left ankle, neck, back, abdomen, bilateral hands, knees, elbow and wrists. Diagnoses include right lateral elbow contusion, left wrist strain and tear of left medial meniscus of knee. Treatments to date include x-ray testing, physical therapy and prescription pain medications. The injured worker continues to experience neck, upper and lower back, bilateral knees, ankle, and wrist pain. Upon examination, there was tenderness of the right radial styloid. There was right lateral elbow swelling and generalized diffuse tenderness of the elbow and forearm right greater than left. A request for Physical therapy two times a week for three weeks, in treatment of the left wrist and bilateral elbows x 6 was made by the treating physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy two times a week for three weeks, in treatment of the left wrist and bilateral elbows x 6:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested additional physical therapy is not medically necessary.