

<b>Case Number:</b>	CM15-0145658		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	10/17/2013
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	07/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2015

### 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:

The injured worker is a 48 year old male, who sustained an industrial injury on 10-17-13. The injured worker has complaints of neck pain that radiates to lower back and to his left shoulder. The injured worker has complaints of right wrist pain that radiates to his elbow and feels numbness on right hand and swelling. The documentation noted there is tenderness to palpation over parvertebral musculature at C5, C6, C7, T8, T9, L4, L5 and S1 (sacroiliac) and there is limited range of motion. The diagnoses have included cervical spondylosis without myelopathy; thoracic or lumbosacral neuritis or radiculitis, unspecified; lumbosacral spondylosis without myelopathy and degeneration of cervical intervertebral disc. Treatment to date has included physical therapy; hand brace; pain medications and pain patches. The request was for physical therapy, twice weekly, right wrist, quantity 12 and physical therapy, twice weekly, right knee and ankle, quantity 12. Several documents within the submitted medical records are difficult to decipher.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, twice weekly, right wrist, QTY: 12: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R.9792.20 / 9792.26 MTUS (Effective July 18, 2009) Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter, Physical Medicine.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) 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 no documentation of specific objective functional improvement with any 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. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

**Physical therapy, twice weekly, right knee and ankle, QTY: 12: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 / 9792.26 MTUS (Effective July 18, 2009) Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Ankle/Foot Chapters, Physical Medicine.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) 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 no documentation of specific objective functional improvement with any 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. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.