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| Case Number: | CM15-0203994 | | |
| Date Assigned: | 10/20/2015 | Date of Injury: | 07/09/2012 |
| Decision Date: | 12/02/2015 | UR Denial Date: | 10/08/2015 |
| Priority: | Standard | Application Received: | 10/16/2015 |

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: Montana, Oregon, Idaho
 Certification(s)/Specialty: Orthopedic Surgery

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 65 year old male with an industrial injury date of 07-09-2012. Medical record review indicates he is being treated for possible regional pain syndrome of right upper extremity, extensor tendinitis and chronic pain syndrome. Subjective complaints (09-30-2015) included pain in right upper extremity rated as 3-4 out of 10 "following the injection therapy." The injured worker indicated physical therapy was helping his right upper extremity and neck. The treating physician indicated the injured worker had made significant gains with physical therapy. The physical therapy note dated 09-24-2015 documented the injured worker had been seen for 11 out of 12 visits and was meeting all physical therapy goals. "Patient has returned to all functional activities with right upper extremity with patient noting no pain, but notes of slight soreness lingering." "At this time patient has been instructed and issued independent home exercise program." Work status is not indicated. Prior treatment included physical therapy, stellate ganglion block, psychological counseling and medications. Objective findings (09-30- 2015) included tenderness of the right extensor tendons. Right hand was minimally tender with diminished edema and hyperalgesia. On 10-08-2015, the request for physical therapy 2 times a week for 3 weeks cervical spine and right upper extremity was denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, 2 times a week for 3 weeks, cervical spine and right upper extremity:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Complex Regional Pain Syndrome (CRPS), Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. Physical Medicine Guidelines:- Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine-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-Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. In this case, the request is for treatment with additional physical therapy visits to treat the diagnosis of CRPS. Based on the documentation the worker does not meet criteria for the diagnosis of CRPS. According to the ODG, the diagnostic criteria are the following: (1) Continuing pain, which is disproportionate to any inciting event; (2) Must report at least one symptom in three of the four following categories: (a) Sensory: Reports of hyperesthesia and/or allodynia; (b) Vasomotor: Reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry; (c) Sudomotor/Edema: Reports of edema and/or sweating changes and/or sweating asymmetry; (d) Motor/Trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); (3) Must display at least one sign at time of evaluation in two or more of the following categories: (a) Sensory: Evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch and/or temperature sensation and/or deep somatic pressure and/or joint movement); (b) Vasomotor: Evidence of temperature asymmetry (>1C) and/or skin color changes and/or asymmetry; (c) Sudomotor/Edema: Evidence of edema and/or sweating changes and/or sweating asymmetry;

(d) Motor/Trophic: Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin); (4) There is no other diagnosis that better explains the signs and symptoms. The submitted documentation fails to demonstrate that the worker meets the objective criteria of CRPS. Therefore, the request for physical therapy exceeds the recommended number of visits set forth in the guidelines, as the worker has already completed 12 visits. The request is not medically necessary.