

<b>Case Number:</b>	CM14-0123541		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	03/19/2005
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Medicine, and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 53 year old female whose date of injury is 03/19/2005. The injured worker was involved in a bus accident and sustained an injury to the right arm. Treatment to date includes cognitive behavioral therapy, physical therapy, and functional restoration program. Note dated 01/22/14 indicates that the injured worker complains of neck and right upper extremity pain. Diagnoses are chronic pain, cervical disc displacement without myelopathy, brachial neuritis, unspecified major depression, and posttraumatic stress disorder. Note dated 03/03/14 indicates that pain is rated as 2/10 visual analog scale (VAS).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy Cervical Spine & Bilateral Upper Extremities X 6 Sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation ODG Neck & Upper Back (updated 5/30/14)ODG Forearm, Wrist & Hand (updated 2/18/14)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, physical therapy

**Decision rationale:** Based on the clinical information provided, the request for physical therapy cervical spine and bilateral upper extremities for six sessions is not considered as medically necessary. There is no comprehensive assessment of recent treatment completed to date or the injured worker's response thereto submitted for review. The most recent physical examination submitted for review is from March. There is no current, detailed physical examination submitted for review and no specific, time limited treatment goals are provided. Given the lack of supporting documentation, the request for physical therapy is not medically necessary in accordance with the Official Disability Guidelines.