

Case Number:	CM15-0011078		
Date Assigned:	01/28/2015	Date of Injury:	05/22/2013
Decision Date:	03/25/2015	UR Denial Date:	01/12/2015
Priority:	Standard	Application Received:	01/19/2015

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

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 49 year old female who sustained an industrial related injury on 5/22/13. The injured worker had complaints of numbness and tingling from the neck into bilateral arms, numbness and tingling in the hands and legs were also noted. Pain in the ankles and back pain was noted. Treatment included occupational therapy and pain psychology sessions. Prescriptions included Norco, Cyclobenzaprine, Meloxicam, and Lyrica. Diagnoses included strain of tendon of foot and ankle, low back pain, complex regional pain syndrome type II of the upper limb, chronic pain syndrome, psychophysiological disorder, and depressive disorder. The treating physician requested authorization for additional occupational therapy 2x3 for the right wrist/hand and physical therapy 2x3 for the right wrist hand. On 1/12/15 the requests were non-certified. Regarding physical therapy the utilization review (UR) physician cited the Medical Treatment Utilization Schedule (MTUS) guidelines and noted additional sessions are not medically necessary without evidence of functional gains obtained with previous sessions. Regarding occupational therapy the UR physician cited the MTUS guidelines and noted there was no documentation of what functional improvement was achieved, how many sessions were attended, and why the injured worker needed to return to supervised therapy rather than continuing an independent home exercise program. Therefore the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the right wrist/hand, twice weekly for three weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section.

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

Decision rationale: Based on the 12/30/14 progress report provided by treating physician, the patient presents with numbness and tingling from the neck into bilateral arms and hands. The request is for PHYSICAL THERAPY FOR THE RIGHT WRIST HAND, TWICE WEEKLY FOR THREE WEEKS. Patient's diagnosis on 12/30/14 included chronic pain syndrome and complex regional pain syndrome, type II, upper limb. Per operative report dated 08/08/14, the patient is status post right stellate ganglion nerve block for the diagnosis of reflex sympathetic dystrophy of the right upper extremity, and reported no benefit. Patient's medications include Cyclobenzaprine, Lyrica, Melatonin, Meloxicam and Norco. Patient is to continue with occupational therapy, per treater report dated 12/30/14. The patient is temporarily totally disabled. MTUS Chronic Pain Management Guidelines, pages 98,99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Treater has not provided reason for the request. Given patient's diagnosis, a short course of physical therapy would be indicated. However, patient has already had occupational therapy and treatment history has not been provided. There is no documentation of functional improvement provided from prior sessions, nor discussion of significant change in symptoms to warrant additional physical therapy. Treater does not discuss any flare-ups, explain why on-going therapy is needed, or reason the patient is unable to transition into a home exercise program. Therefore, the request IS NOT medically necessary.

Additional occupational therapy for the right wrist/hand, twice weekly for three weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section.

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

Decision rationale: Based on the 12/30/14 progress report provided by treating physician, the patient presents with numbness and tingling from the neck into bilateral arms and hands. The request is for ADDITIONAL OCCUPATIONAL THERAPY FOR THE RIGHT WRIST/HAND TWICE WEEKLY FOR THREE WEEKS. Patient's diagnosis on 12/30/14 included chronic pain syndrome and complex regional pain syndrome, type II, upper limb. Per operative report dated 08/08/14, the patient is status post right stellate ganglion nerve block for the diagnosis of

reflex sympathetic dystrophy of the right upper extremity, and reported no benefit. Patient's medications include Cyclobenzaprine, Lyrica, Melatonin, Meloxicam and Norco. Patient is to continue with occupational therapy, per treater report dated 12/30/14. The patient is temporarily totally disabled. MTUS Chronic Pain Management Guidelines, pages 98,99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended."Treater has not provided reason for the request. Given patient's diagnosis, a short course of physical therapy would be indicated. However, patient has already had occupational therapy and treatment history has not been provided. There is no documentation of functional improvement provided from prior sessions, nor discussion of significant change in symptoms to warrant additional physical therapy. Treater does not discuss any flare-ups, explain why on-going therapy is needed, or reason the patient is unable to transition into a home exercise program. Therefore, the request IS NOT medically necessary.