

Case Number:	CM14-0133028		
Date Assigned:	08/22/2014	Date of Injury:	02/20/2002
Decision Date:	10/27/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	08/20/2014

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 is licensed to practice in California. 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:

This 59 year-old female prep cook sustained an injury on 2/20/2002 from a slip and fall after stepping on a kitchen mat while employed by [REDACTED]. Request(s) under consideration include Physical therapy 3 times per week for 6 weeks (18 sessions) for the cervical spine, right shoulder and right wrist (2 times per week for pool therapy and once per week land physical therapy). Diagnoses include s/p left knee arthroscopic medial meniscectomy, chondroplasty on 4/5/13 with 18 post-operative PT sessions and s/p rotator cuff repair with partial claviclectomy. Report of 2/21/14 from the provider noted the patient has past medical history of diabetes. Medications include Tylenol#3 and Xanax. Findings of EMG/NCS showed diffuse sensory polyneuropathy and findings suggestive of bilateral chronic active L5-S1 radiculopathy. Report of 6/30/14 from the provider noted the patient with 10 days post arthroscopic rotator cuff repair with 80 degrees range on continuous passive motion. The patient was noted to not have therapy yet. No complaints or objective findings were documented of the right shoulder and left wrist. Report of 7/28/14 from another provider noted the patient s/p left shoulder surgery on 6/20/14. Current symptoms include left knee pain at 4/10, left foot pain at 2/10, and low back at 1/10 almost gone with left SI joint pain at 1/10. Exam showed neck supple; tender coccyx, left SI joint and left buttock; no tenderness of lumbosacral spine; ambulates with limp; gait slow. There was no exam of shoulder or wrist documented. Recommendation was to repeat venous ultrasound for chronic edema. The request(s) for Physical therapy 3 times per week for 6 weeks (18 sessions) for the cervical spine, right shoulder and right wrist (2 times per week for pool therapy and once per week land physical therapy) was deemed not medically necessary on 8/20/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times per week for 6 weeks (18 sessions) for the cervical spine, right shoulder and right wrist (2 times per week for pool therapy and once per week land physical therapy): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Rotator cuff syndrome/Impingement syndrome.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no clinical findings of the shoulder or wrist without evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. The Physical therapy 3 times per week for 6 weeks (18 sessions) for the cervical spine, right shoulder and right wrist (2 times per week for pool therapy and once per week land physical therapy) is not medically necessary and appropriate.