

Case Number:	CM14-0171299		
Date Assigned:	10/23/2014	Date of Injury:	12/18/2010
Decision Date:	11/25/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/16/2014

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 Family Medicine 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 is a 50-year-old male patient who reported an industrial injury on 12/18/2010, almost four (4) years ago, attributed to the performance of his usual and customary job duties as a tow truck driver when he sustained burns. The patient has received ongoing medications, physical therapy, and surgical intervention. The patient complains of chronic shoulder pain, right knee pain, and bilateral hand/wrist pain. The patient is status post multiple debridement and skin grafting surgical procedures. The patient reported intermittent swelling of the right hand, difficulty performing fine hand movements, ongoing numbness and tingling of all digits in both hands at night. The objective findings on examination included pigmentation changes on both hands thicken scar contractures and post traumatic skin changes; Tinel's test was negative; volar flexion/compression test cause paresthesias of the right thumb, index, long fingers. The patient also complained of right knee pain. The objective findings on examination included swelling of the right knee; negative Lachman's, no ligamentous instability, full extension and flexion, positive plantar flexion and dorsiflexion, no motor deficits. The patient had reported some improvement with corticosteroid injection on 6/13/2014. The patient has not received physical therapy for his right knee in the last six months.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve physical therapy visits with e-stim, exercise, and massage: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Medicine Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 97-98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg chapter---Knee post operative arthroscopy

Decision rationale: The request for an additional 12 sessions of PT to the right knee after prior sessions of PT were provided was not supported with objective evidence to support medical necessity. The patient is almost four years status post date of injury for a knee sprain/strain and should be in a self-directed home exercise program. The prior UR determination provided for nine sessions of physical therapy; however, the patient was noted to have had prior physical therapy approximately six (6) months previous. The request for additional physical therapy represented maintenance care. There are no documented objective findings to support the medical necessity of additional PT over the recommended self-directed home exercise program. The patient has received prior sessions of rehabilitation PT. There is no medical necessity for more than eight (8) total sessions of PT for the rehabilitation of the knee. The patient is reported to be four (4) years status post date of injury to the right knee and has exceeded the California MTUS time period recommended for rehabilitation of the knee. The request for additional sessions of PT with electrical stimulation, massage therapy, and exercises is in excess of the number recommended by the CA MTUS. The patient is documented to have pain with no objective findings on that cannot be addressed in a HEP. There is no evidence the patient cannot increase strength and conditioning in a self-directed home exercise program. The treating physician provided no rationale supported with objective evidence to support the medical necessity of additional physical therapy postoperatively in excess of the number recommended by the California MTUS. The request exceeds the CA MTUS recommendation of a total of nine (9) sessions over 8 weeks for the rehabilitation of the knee or LE s/p sprain/strain with integration into a self-directed home exercise program. The patient has received prior sessions and should be in a HEP. The subsequent conditioning and strengthening is expected to be accomplished with the self-directed home exercise program. There is no demonstrated medical necessity for the requested 12 sessions of additional physical therapy including electrical stimulation, massage therapy, and exercises. The request is not medically necessary.