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| Case Number: | CM14-0043299 | | |
| Date Assigned: | 07/02/2014 | Date of Injury: | 08/15/2005 |
| Decision Date: | 09/19/2014 | UR Denial Date: | 03/31/2014 |
| Priority: | Standard | Application Received: | 04/10/2014 |

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 patient sustained an injury on 8/15/05 while employed by [REDACTED]. A report of 3/12/13 had diagnoses include lumbar spine disc extrusion with radiculopathy; thoracic spine strain; cervical spine disc bulges; right shoulder strain; s/p left shoulder surgery; right knee internal derangement s/p knee surgery 8/5/11; bilateral elbow strain; compensatory left knee strain and left ankle strain. The patient noted neck, upper back, bilateral shoulder, bilateral elbow, bilateral knee, and left ankle pain radiating to bilateral lower extremities with associated numbness and tingling. Exam showed positive foramina compression; positive Kemp's/ SLR/ apprehension/ depressor test with varus/valgus stress. Treatment included medication refills of Ultram and Soma; f/u multiple specialists with ENT/Ortho/Internal medicine/ Dental/ Neurologist/ Ophthalmology/ 2 orthopedist. The patient remained TTD. No other report or updated information provided for review. The request(s) for Physical therapy 2x6, right shoulder was non-certified on 3/31/14 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 2x6, right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

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 evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The MTUS 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. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The request is not medically necessary and appropriate.