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| Case Number: | CM14-0076892 | | |
| Date Assigned: | 07/18/2014 | Date of Injury: | 02/12/2014 |
| Decision Date: | 08/29/2014 | UR Denial Date: | 05/16/2014 |
| Priority: | Standard | Application Received: | 05/27/2014 |

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:

The injured worker is a 62-year-old female who reported an injury on 02/12/2014. The mechanism of injury was noted as a fall. The injured worker's diagnoses included the fracture of the right radius, unspecified, closed; right shoulder supraspinatus tendon tear and right knee strain. Previous treatments included 6 physical therapy visits for the right shoulder and right knee, 24 physical therapy visits for the right wrist and a cortisone injection. Diagnostic studies included MRI of the right shoulder on 06/24/2014, unofficial results noted right supraspinatus tendon tear and an X-ray of the right wrist, date not provided, unofficial results noted fracture of the distal radial wrist with a chip fragment. Surgical history was not provided in the medical records submitted for review. It was noted on the progress report dated 06/26/2014 the injured worker complained of pain in the right upper arm with movement but has more severe pain in the right shoulder. The injured worker denied any pain or swelling of the right knee. The injured worker also complained of right wrist pain rated 3/10. The injured worker reported significant improvement in the right knee with 6 physical therapy visits and current pain level was 1/10. The injured worker also reported right shoulder pain 5/10 after 6 physical therapy treatments. The objective findings noted the injured worker was unable to elevate right arm above 70 degrees secondary to pain. There was decreased range of motion with all planes due to pain in the upper arm. The objective findings further noted palpation of the right knee revealed no tenderness over lateral knee area. The right knee range of motion was normal to flexion and extension without pain and crepitus. Negative Lachman's and McMurray's test were also noted. The injured worker's medications include amlodipine, hydrochlorothiazide, atenolol, and Losartan. The dosage and frequency of the medications were not provided in the medical records submitted for review. The provider requested physical therapy 2 times a week for 3 weeks. The rationale for the requested treatment plan was not provided in the medical records submitted for review. The

request for authorization form dated 02/25/2014 specifying physical therapy to the right knee 6 treatments with 2 treatments per week for 3 weeks was provided with the medical records submitted for review. The request for authorization form dated 05/20/2014 specifying physical therapy for the shoulder 6 treatments with 2 treatments per week for 3 weeks was provided within the medical records submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy two (2) times a week for three (3) weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter: Physical Therapy Guidelines.

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

Decision rationale: The request for physical therapy 2 times a week for 3 weeks is not medically necessary. The injured worker has a history of right shoulder, right knee and right wrist pain. The injured worker has participated in 6 physical therapy visits for the right shoulder and 6 for the right knee and 24 physical therapy visits for the right wrist. The California MTUS Guidelines recommend physical medical treatment stating active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The Guidelines state to allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The recommended number of sessions for myalgia and myositis is 9-10 visits over 8 weeks. The documentation provided noted the patient has participated in physical therapy for the right knee, right shoulder and right wrist. The documentation also noted decrease in pain with completion of therapy for the right knee. However, there documentation provided did not indicate the injured worker incorporated a home exercise program as an extension of the treatment process in order to maintain improvement levels. There was also a lack of documentation indicating significant objective functional deficits and the documentation provided failed to indicate improved functional capacity to warrant continued therapy. The requested number of sessions in addition to the completed sessions would exceed the maximum recommended by the guidelines. There is a lack of documentation to indicate significant exceptional factors to warrant continued therapy beyond the maximum guideline. Additionally the requested treatment plan failed to specify which area was the focus of additional therapy. As such, the request for physical therapy 2 times a week for 3 weeks is not medically necessary.