

<b>Case Number:</b>	CM14-0202900		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	12/15/2013
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	11/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2014

### 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. 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 57-year-old male who reported an injury on 12/15/2013. The mechanism of injury reportedly occurred as cumulative trauma. His diagnosis included cervical disc disorder with myelopathy, shoulder region disc necrosis, medial meniscus tear of the knee, and trigger finger. His past treatments include cortisone injections and physical therapy. Pertinent diagnostics include an MRI of the right knee without contrast, performed on 12/21/2014, with findings of an oblique tear of the posterior horn of the medial meniscus extending to the under surface of this structure. The lateral meniscus is identified and is intact. There is bright signal of the anterior cruciate ligament, which may represent intrasubstance tear or sprain of this structure. The posterior cruciate ligament is identified as intact. There is a large amount of joint effusion present. There is chondromalacia of the medial and lateral articular margins of the patella. Transverse images reveal the patella to be in appropriate position in the trochlear groove. There is bright signal of the medial collateral ligament, which may represent intrasubstance tear of this structure, and this remains attached. The lateral collateral ligament is identified and is intact. The bones demonstrate normal signal and morphology. His surgical history includes a right knee arthroscopy, performed on 06/09/2014. The injured worker presented on 08/06/2014 for a postoperative visit after a right knee arthroscopy, performed on 06/09/2014. The injured worker complained of some residual weakness. Additionally, he complained of right biceps tendinitis and impingement. The injured worker further stated that he was going to therapy for his shoulder; however, it was not improving. Physical examination of the right knee, revealed a healed incision, no ecchymosis, range of motion was 0 to 130, he was positive for weakness and

mild quad atrophy. Upon physical examination of the right shoulder, the injured worker was positive for weakness and impingement. Forward flexion was to 140 degrees, abduction was to 120 degrees, external rotation was to 50 degrees. Additionally, the injured worker had positive Neer's and Hawkins signs. His current medication regimen was not provided within the documentation submitted for review. The treatment plan included for the injured worker to continue therapy for the knee and shoulder. The rationale for the request was for strengthening for the knee. A Request for Authorization form, dated 08/16/2014, was provided within the documentation 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 (no frequency or duration noted), provided on September 8, October 1, and October 3, 2014:** 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 Medicine Page(s): 98-99.

**Decision rationale:** The request for Physical therapy (no frequency or duration noted), provided on September 8, October 1, and October 3, 2014 is not medically necessary. The injured worker has knee and shoulder pain. The California MTUS Treatment Guidelines recommend physical therapy and states that it 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. Additionally, the guidelines state that 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 documentation submitted for review failed to provide a frequency, duration of treatment and requested body part/parts for physical therapy. Given the above, the request as submitted does not meet medical necessity. As such, the request for Physical therapy (no frequency or duration noted), provided on September 8, October 1, and October 3, 2014 is not medically necessary.