

Case Number:	CM14-0056363		
Date Assigned:	07/18/2014	Date of Injury:	03/09/2012
Decision Date:	12/08/2015	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/25/2014

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 sustained an industrial injury on March 09, 2012. The worker is being treated for: right knee and right shoulder injury; lumbar discopathy, internal derangement bilateral shoulders status post left surgery; right CTS with double crush; right cubital tunnel; internal derangement bilateral hips, right knee meniscus tear and bilateral plantar fasciitis. Subjective: February 11, 2014 he reported "persistent pain of the upper extremities," and the left upper extremity has improved. He still has residual post operative pain. March 11, 2014 he reported complaint of right shoulder and right knee pain. Objective: February 11, 2014 noted lumbar spine with tenderness from the mid to distal lumbar segment and pain with terminal movement, seated nerve root test is positive. The bilateral upper extremities showed well healed cubital carpal tunnel release scars, right upper with positive Tinel's at the elbow and both Tinel's and Phalen's positive at the wrist. There is noted pain with terminal flexion and Dysesthesia at the digits. March 11, 2014 noted right shoulder range of motion, forward flexion and abduction at 155 degrees, external rotation at 90 degrees and internal rotation to L5 and tenderness at the subacromial bursa. There is a positive Hawkin's, Kennedy, and Neer's testing. The right knee range of motion noted: zero to 125 degrees positive for patellofemoral crepitation and grind. There is a trace Lachman and anterior drawer testing. He has notable laxity with trace to one plus, and one plus effusion and vargus alignment of the knee. Diagnostic: MRI of right knee October 2012, recent knee radiography study. Treatment: recommendation for additional physical therapy and visco-supplementation to the right knee. On March 25, 2014 a request was

made for physical therapy 12 sessions for the right knee and 12 sessions for the right shoulder that were both noncertified by Utilization Review on April 01, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Right Knee 2 x per Week for 6 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines: Leg Procedure Summary- physical therapy guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization from the formal physical therapy already rendered to support further treatment. There has not been a change in neurological compromise or red-flag findings demonstrated for PT at this time. Submitted reports have also not adequately identified the indication to support for excessive quantity of 12 PT sessions without extenuating circumstances established beyond the guidelines. The Physical Therapy Right Knee 2x per Week for 6 Weeks is not medically necessary and appropriate.

Physical Therapy Right Shoulder 2 x per Week for 6 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

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 Chronic Pain Guidelines allow for 8-10 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 progressive neurological clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this 2012 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 Physical Therapy Right Shoulder 2x per Week for 6 Weeks is not medically necessary and appropriate.