

<b>Case Number:</b>	CM15-0011247		
<b>Date Assigned:</b>	01/28/2015	<b>Date of Injury:</b>	01/17/2011
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2015

### 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: New York

Certification(s)/Specialty: Internal Medicine

### 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 52-year-old male, who sustained an industrial injury on January 17, 2011, when a stock stand fell tearing the right arm. He has reported feeling the right arm tear. The diagnoses have included right shoulder cuff tear, right shoulder tendinitis, cervical radiculopathy, and meniscus tear of the right knee. Treatment to date has included right shoulder surgery, right knee arthroscopy, physical therapy, and medications. Currently, the injured worker complains of sharp, stabbing pain to the right shoulder, frequent numbness and tingling to the right hand, knee pain, and persistent numbness to the lower legs. An Orthopedic Physician's visit dated November 19, 2014, right shoulder examination noted tenderness over the anterolateral border of the right acromion and over the right long head of the biceps. The right knee examination revealed mild swelling and tenderness over the medial joint, with tenderness about the anterior aspect, lateral aspect, medial aspect, medial joint line, lateral joint line, and over the patella. On December 18, 2014, Utilization Review non-certified aquatic physical therapy right knee and right shoulder QTY: 12, knee brace, MRI right shoulder, range of motion (ROM) muscle testing thoracic and lumbar spine performed November 19, 2014, range of motion (ROM) muscle testing thoracic and lumbar spine performed November 19, 2014, and physical therapy evaluation and treatment for thoracic and lumbar spine QTY: 12, noting the guideline criteria had not been met and the requests were not medically necessary. The MTUS Chronic Pain Medical Treatment Guidelines and the MTUS American College of Occupational and Environmental Medicine (ACOEM) Guidelines were cited. On January 20, 2015, the injured worker submitted an application for IMR for review of aquatic physical therapy right knee and

right shoulder QTY: 12, knee brace, MRI right shoulder, range of motion (ROM) muscle testing thoracic and lumbar spine performed November 19, 2014, range of motion (ROM) muscle testing thoracic and lumbar spine performed November 19, 2014 and physical therapy evaluation and treatment for thoracic and lumbar spine QTY: 12.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Aquatic physical therapy right knee and right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

**Decision rationale:** MTUS recommends aquatic therapy as an optional form of exercise therapy, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Documentation does not support the indication for aquatic therapy as the injured worker has not failed land based physical therapy. The request for Aquatic physical therapy right knee and right shoulder is not medically necessary.

**Knee brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Initial Care, pg 340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Knee brace.

**Decision rationale:** Per guidelines, knee braces may be used in treating patients with conditions including Knee instability, ligament insufficiency/deficiency, reconstructed ligament, painful failed total knee arthroplasty and painful unicompartmental osteoarthritis. MTUS goes on to state that braces need to be used in conjunction with a rehabilitation program and that the benefits may be more emotional (i.e., increasing the patient's confidence) than medical. The injured worker complains of right knee pain and is diagnosed with right knee meniscus tear. Documentation reveals that with physical therapy, the knee stabilized to a point where the injured worker no longer needs to use a cane. Physical examination findings fail to show severe instability of the injured worker's knee that would warrant the use of a knee brace. The request for a left knee brace is not medically necessary.

**MRI right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 207.

**Decision rationale:** MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination, failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker has undergone arthroscopic shoulder surgery followed by post-operative Physical Therapy with no significant improvement in pain. Chart documentation fails to show any red flags or unexplained physical findings on examination that would warrant additional imaging. The request for MRI of the shoulder is not medically necessary by MTUS.

**ROM Muscle Testing thoracic and lumbar spine (performed 11/19/14) Qty: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): Physical Exam, Neurologic Screening, testing for muscle strength, pg 293.

**Decision rationale:** The neurologic examination is recommended as a part of a routine physical examination when there is need to test for evidence of nerve root impairment, peripheral neuropathy, or spinal cord dysfunction. As such, the request for special testing for ROM Muscle Testing thoracic and lumbar spine (performed 11/19/14) Qty: 1 is not medically necessary.

**ROM Muscle Testing thoracic and lumbar spine (performed 11/19/14) Qty: 1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): Physical Exam, Neurologic Screening, testing for muscle strength, pg 293.

**Decision rationale:** The neurologic examination is recommended as a part of a routine physical examination when there is need to test for evidence of nerve root impairment, peripheral neuropathy, or spinal cord dysfunction. As such, the request for special testing for ROM Muscle Testing thoracic and lumbar spine (performed 11/19/14) Qty: 1 is not medically necessary.

**Physical therapy Evaluation & Treatment for thoracic and lumbar spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Chapter.

**Decision rationale:** MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of Lumbar sprains and strains and Intervertebral disc disorders without myelopathy. 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. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency. When the treatment duration and/or number of visits exceed the guidelines, exceptional factors should be noted. Documentation at the time of the Physical Therapy request under review fails to reveal the nature and number of previous therapy visits provided for the injured worker's complaints of mid to low back pain. There is also no evidence of exceptional factors. With guidelines not being met, the request for Physical therapy Evaluation & Treatment for thoracic and lumbar spine is not medically necessary.