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| Case Number: | CM15-0136123 | | |
| Date Assigned: | 07/24/2015 | Date of Injury: | 11/10/2011 |
| Decision Date: | 08/24/2015 | UR Denial Date: | 07/07/2015 |
| Priority: | Standard | Application Received: | 07/14/2015 |

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: California

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 70 year old female, who sustained an industrial injury on November 10, 2011. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having status post right shoulder surgery, status post remote left knee meniscectomy, left knee moderate to severe osteoarthropathy and medial meniscus tear, right elbow pain, and right median neuropathy. Treatment and diagnostic studies to date has included medication regimen, physical therapy, use of a transcutaneous electrical nerve stimulation unit, use of heat, and use of ice. In a progress note dated February 02, 2015 the treating physician reports complaints of pain to the left knee, right shoulder, right wrist, and hand. Examination reveals tenderness to the left knee with swelling, decreased range of motion to the right shoulder, spasm to the calf muscles, spasm to the right deltoid, and spasm to the right cervical trapezius. The injured worker's pain level was rated an 8 out of 10 to the left knee and a 5 out of 10 to the right shoulder, right wrist, and the right hand. The treating physician noted prior physical therapy of an unknown quantity, but the medical records provided did not indicate if the injured worker had any functional improvement secondary to prior physical therapy. The treating physician requested physical therapy three times a week for four weeks for the right shoulder for active therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times a week for 4 weeks for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 474. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines.

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

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.