

Case Number:	CM15-0193191		
Date Assigned:	10/07/2015	Date of Injury:	03/24/2011
Decision Date:	11/16/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	10/01/2015

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

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 67 year old female, who sustained an industrial injury on 3-24-11. The injured worker is being treated for right carpal tunnel syndrome, right wrist sprain-strain, left knee internal derangement, left knee lateral meniscus tear, left knee sprain-strain, anxiety, depression, irritability and nervousness. Treatment to date physical therapy (without documentation of benefit) included oral medications including Alprazolam, topical creams, left knee surgery and activity modifications. On 8-24-15, the injured worker complains of activity dependent moderate sharp, throbbing, right wrist pain with stiffness, numbness, tingling, weakness and cramping; she notes relief from medication and left knee pain described as constant severe, sharp, stabbing, throbbing, burning left knee pain with heaviness, tingling and weakness and muscle spasms; left knee surgery is scheduled and she also notes depression, anxiety and irritability symptoms are increased with chronic pain. Objective findings on 8-24-15 revealed right wrist decreased median nerve sensation with painful range of motion and decreased median nerve sensation with tenderness to palpation of lateral wrist, medial wrist and volar wrist; hinged knee brace is noted on left knee with a waddles gait, 4 point cane, swelling of right knee, decreased range of motion and tenderness to palpation of anterior, lateral and medial left knee. The treatment plan included 12 physical therapy visits post-op. On 9-2-15 request for 12 physical therapy visits and once a month range of motion testing was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 6 weeks for right wrist and left knee: Upheld

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

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

Decision rationale: Review indicates the patient is s/p left knee arthroscopy on 7/17/15 with 24 post-op PT visits authorized, now with request for an additional 12 visits to the left knee and right wrist. Chronic Pain Guidelines for Post-surgical treatment for cruciate ligament repair allow for 24 visits over 16 weeks for a post-surgical physical medicine treatment period. It is not clear if the patient has completed the 24 post-op PT visits authorized; however, submitted reports have not adequately demonstrated the indication to support further physical therapy beyond the guidelines criteria. The patient's arthroscopy is without documented functional limitations or complications to allow for additional physical therapy. There is no reported functional improvement from treatment already rendered nor what limitations are still evident for further therapy as the patient remained TTD. Regarding the PT for the wrist, there is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this 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 2 times a week for 6 weeks for right wrist and left knee is not medically necessary and appropriate.

Range of motion testing once per month: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures.

Decision rationale: Computerized ROM/strength MTUS, ODG, or AMA Guides do not support testing. Evaluation of range of motion and motor strength are elementary components of any physical examination for musculoskeletal complaints and does not require computerized equipment. In addition, per ODG, the relation between range of motion measurements and functional ability is weak or even nonexistent with the value of such tests like the sit-and-reach test as an indicator of previous spine discomfort is questionable. They specifically noted computerized measurements to be of unclear therapeutic value. Submitted reports have not adequately provided extenuating circumstances or clear indication for computerized testing over the standard practice of manual evaluation with use of inclinometer. Medical necessity for computerized strength and ROM outside recommendations from the Guidelines has not been established. The Range of motion testing once per month is not medically necessary and appropriate.

