

Case Number:	CM15-0206598		
Date Assigned:	10/23/2015	Date of Injury:	12/15/2011
Decision Date:	12/07/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	10/20/2015

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: 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 50 year old male, who sustained an industrial injury on 12-15-2011. A review of the medical records indicates that the injured worker is undergoing treatment for cervical discopathy, bilateral shoulder rotator cuff tendinitis-bursitis with rotator cuff tear, bilateral carpal tunnel syndrome, lumbar discopathy with nerve root compression, left knee lateral meniscus tear, chronic insomnia, chronic pain syndrome, and prolonged depressive reaction. On 9-22-2015, the injured worker reported intermittent moderate bilateral knee pain and intermittent moderate neck pain with radiation to the bilateral upper extremities with numbness and tingling in the hands and headaches. The Primary Treating Physician's report dated 9-22-2015, noted the injured worker reported his low back pain had improved since surgery. The physical examination was noted to show the cervical spine with tenderness to palpation about the paracervical musculature with muscle spasm and restricted range of motion (ROM) due to complaints of discomfort and pain. Examination of the bilateral knees revealed mild tenderness on the anterior-lateral joint line with crepitus, positive McMurray's test bilaterally, and restricted range of motion (ROM) due to complaints of discomfort and pain. Prior treatments and evaluations have included a lumbar laminectomy 6-2-2015, physical therapy for gait abnormality, a right knee MRI dated 8-27-2015 that medial collateral ligament sprain, a horizontal cleavage tear of the posterior horn of the medial meniscus, and prepatellar and infrapatellar soft tissue swelling and subcutaneous edema, and a left knee MRI dated 8-27-2015 that showed prepatellar and infrapatellar soft tissue swelling and subcutaneous edema, medial collateral ligament sprain, and fibular collateral ligament sprain. The treatment plan was

noted to include requests for authorization for physical therapy for the cervical spine and bilateral knees, a consultation with a shoulder surgeon, a knee brace, and bilateral knee injections, with Nabumetone and Omeprazole prescribed. The injured worker's work status was noted to be work with restriction limited to sedentary work. The request for authorization dated 9-28-2015, requested bilateral knee cortisone injection 1, bilateral knee physical therapy 2 times a week for 4 weeks, and cervical spine physical therapy 2 times a week for 4 weeks. The Utilization Review (UR) dated 10-2-2015, non-certified the requests for bilateral knee cortisone injection 1, bilateral knee physical therapy 2 times a week for 4 weeks and cervical spine physical therapy 2 times a week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral knee cortisone injection 1: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Corticosteroid Injections, pages 294-295.

Decision rationale: ODG Guidelines recommend corticosteroid injections for short-term use with beneficial effect of 3-4 weeks for diagnosis of osteoarthritic knee pain, but unlikely to continue beyond as long-term benefits have not been established. Documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria, which requires knee pain and at least 5 of the following to include Bony enlargement; Bony tenderness; Crepitus (noisy, grating sound) on active motion; Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; Less than 30 minutes of morning stiffness; No palpable warmth of synovium; Over 50 years of age; Rheumatoid factor less than 1:40 titer (agglutination method); and Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm³), not demonstrated here. Additionally, there needs to be documented failed conservative treatment with pain interfering with functional activities and injection should be intended for short-term control of symptoms or delay TKA. Submitted reports have not demonstrated at least 5 elements above nor shown failed treatment trial, plan for surgical intervention for severe OA or limitations in ADLs to meet guidelines criteria. The Bilateral knee cortisone injection 1 is not medically necessary and appropriate.

Bilateral knee physical therapy 2 times a week for 4 weeks: 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.

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 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 clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic 2011 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 Bilateral knee physical therapy 2 times a week for 4 weeks is not medically necessary and appropriate.

Cervical spine physical therapy 2 times a week for 4 weeks: 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.

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 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 for this 2011 injury. 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 PT sessions without extenuating circumstances established beyond the guidelines. The Cervical spine physical therapy 2 times a week for 4 weeks is not medically necessary and appropriate.