

Case Number:	CM15-0086048		
Date Assigned:	05/08/2015	Date of Injury:	05/29/2014
Decision Date:	06/24/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	05/05/2015

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 40-year-old male who sustained an industrial injury on 05/29/2014. Mechanism of injury was an automobile accident, where he sustained multiple injuries to multiple body parts. Diagnoses include lateral meniscus tear, status post left knee arthroscopy on 02/06/2015, right wrist healed fracture of the radial styloid, partial tear of the extensor pollicis brevis tendon and strain to the scapholunate ligament, and post-traumatic stress disorder. Treatment to date has included diagnostic studies, surgery, medications, and physical therapy. Electromyography done on 04/23/2015 reveals normal Electromyography of left lower extremity and lumbar paraspinal muscles. Nerve conduction studies of left were normal along with the left posterior tibial nerve, including medial and lateral plantar branches. A Magnetic Resonance Imaging of the right-hand showed partial tear distal extensor hallucis brevis tendon, small ganglion cyst on the dorsal surface of the carpal ligament complex and slightly deformed appearance of the distal portion of the first metacarpal likely due to and remote healed fracture, and mild degenerative changes to the first metacarpophalangeal joint. Magnetic Resonance Imaging of the right wrist showed healing undisplaced fracture styloid process of the radius, subacute partial tear extensor pollicis brevis tendon with tenosynovitis, and probably sprain scapholunate ligament. His medications include Atenolol, Aspirin, a stool softener, Voltaren Gel and Norco. A physician progress note dated 04/06/2015 documents the injured worker was seen for his second postoperative visit. He has pain radiating from his mid-thigh to his mid-calf on the left lower extremity. He continues to wear a wrist brace for his right wrist. He has a history of radial styloid fracture from his accident. He continues to complain of anxiety attacks, difficulty with sleeping and difficulty with activity due to his left knee. He rates his pain as 4 out of 10. His incision is well healed with no swelling, erythema, or ecchymosis. There is some

tenderness over the posterior aspect of his leg from the distal femur to about mid-calf. He also has some tenderness along the anterior aspect of his knee. Range of motion is 5 to 120 degrees. He walks with a limp. Treatment requested is for outpatient additional physical therapy to the right wrist two (2) times a week for six (6) weeks, and outpatient additional post-operative physical therapy (PT) to the left knee, two times a week for six (6) weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient additional post-operative physical therapy (PT) to the left knee, two times a week for six (6) weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Post-surgical Therapy for Knee, pages 14-15 Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5): Postsurgical treatment: (Meniscectomy): 12 visits over 12 weeks.

Decision rationale: The patient is s/p knee arthroscopy on 2/6/15 and has completed at least 12 post-op PT visits with request for an additional 12 sessions. The Chronic Pain Guidelines, post-operative therapy allow for 12 visits over 12 weeks for arthroscopic surgery over a postsurgical physical medicine treatment period. Submitted reports have not adequately demonstrated the indication to support further physical therapy beyond the initial guidelines criteria. The patient is without documented functional improvement from the extensive PT visits rendered. There was no post-operative complications or comorbidities noted to allow for additional physical therapy beyond guidelines recommendations. The patient should have been instructed and is performing an independent HEP. Submitted reports have not demonstrated clear specific indication and necessity to support for a continued conjunctive formal PT program. The Outpatient additional post-operative physical therapy (PT) to the left knee, two times a week for six (6) weeks is not medically necessary and appropriate.

Outpatient additional physical therapy to the right wrist two (2) times a week for six (6) weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy (PT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

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 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 Outpatient additional physical therapy to the right wrist two (2) times a week for six (6) weeks is not medically necessary and appropriate.