

Case Number:	CM14-0125307		
Date Assigned:	09/24/2014	Date of Injury:	03/16/2012
Decision Date:	11/13/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	08/07/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a male patient with the date of injury of March 16, 2012. A Utilization Review was performed on July 14, 2014 and recommended modification of physical therapy 3 times a week for 6 weeks shoulder, knee wrists to physical therapy 2 times a week for 3 weeks shoulder, knee, wrists. A Progress Report dated June 23, 2014 identifies Subjective Complaints of frequent, severe right shoulder pain, moderate bilateral knee pain, and frequent, moderate right hand pain. Objective Findings identify tenderness on palpation with limited painful range of motion and positive orthopedic evaluation to the bilateral knees, right shoulder, and right hand. Decreased sensory at C6-7 right/L5-S1 right. Diagnoses identify post-surgery left knee, post-surgery right knee, shoulder impingement with tendonitis, right chest pain, shortness of breath, right hand CTS, headaches, psych, sexual dysfunction, and sleep disorder. Treatment Plan identifies postsurgical PT (physical therapy) rehab quad strengthening.

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 3 weeks, shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines n(ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy

Decision rationale: Regarding the request for Physical Therapy 2 times a week for 3 weeks, shoulder, Chronic Pain Medical Treatment Guidelines recommend a short course 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. ODG recommends 10 physical therapy visits. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the 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. In light of the above issues, the currently requested Physical Therapy 2 times a week for 3 weeks, shoulder is not medically necessary.

Physical Therapy 2 times a week for 3 weeks, knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10; 24.

Decision rationale: Regarding the request for Physical Therapy 2 times a week for 3 weeks, knee, California MTUS Post-Surgical Treatment Guidelines recommend up to 12 total PT (physical therapy) sessions after meniscectomy, with half that amount recommended initially. 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 documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the 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. In light of the above issues, the currently requested Physical Therapy 2 times a week for 3 weeks, knee is not medically necessary.

Physical Therapy 2 times a week for 3 weeks, wrists: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Physical medicine treatment

Decision rationale: Regarding the request for Physical Therapy 2 times a week for 3 weeks, wrists, Chronic Pain Medical Treatment Guidelines recommend a short course 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. ODG recommends 1-3 visits for medical treatment of CTS. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the 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. In light of the above issues, the currently requested Physical Therapy 2 times a week for 3 weeks, wrists is not medically necessary.