

Case Number:	CM14-0213503		
Date Assigned:	12/31/2014	Date of Injury:	09/27/2012
Decision Date:	02/25/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 49 year old patient with date of injury of 09/27/2012. Medical records indicate the patient is undergoing treatment for de Quervains stenosing tenosynovitis, right fifth digit stenosing tenosynovitis, possible left dorsal wrist ganglion cyst versus carpometacarpal boss, depression/anxiety, chronic pain and postmenopausal states/p C3 through T1 fusions and reconstructions. Subjective complaints include bilateral hand pain, left thumb base pain, right small finger triggering, achiness to back, numbness in bilateral upper extremities; mild bilateral achiness in bilateral arms, pain rated 1-8/10 depending on activity. Objective findings include slightly decreased range of motion of bilateral wrists and flexion and extension, swelling to left wrist consistent with ganglion cyst, right fifth digit tenderness to palpation, pain to palpation of first dorsal compartment on left, Finkelstein's test on left is lightly positive; positive McMurray test with tenderness medially on the right knee, crepitus. MRI of thoracic spine dated 10/21/2014 reveals multilevel degenerative changes as described, noting ligamentous hypertrophy in the lower thoracic spine; mild spinal canal stenosis is noted at T10-T11; no significant neural foraminal stenosis is seen at any level. X-ray of cervical spine dated 10/21/2014 revealed status post C4 through T1 fusion without evidence of complication; cephalad disc spaces are preserved, multilevel foraminal stenosis. Treatment has consisted of surgical intervention, steroid injection to thumb, chiropractic treatments, physical therapy, epidural injection, modification of activities, Percocet, Tramadol, Prozac and Melatonin. The

utilization review determination was rendered on 11/19/2014 recommending non-certification of 12 additional physical therapy sessions, thoracic spine and right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 additional physical therapy sessions to the thoracic spine and right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter and Knee & Leg Chapter, Physical Therapy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 329-360, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 24-25. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Knee (Acute & Chronic) Physical Therapy, ODG Preface - Physical Therapy

Decision rationale: California MTUS guidelines refer to Physical Medicine Guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar and Thoracic sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. Regarding physical therapy, ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." The request for 12 sessions is in excess of guidelines. ODG does recommend that post-surgical thoracic/lumbar physical therapy range from 16-30+ sessions over 8-16 weeks. ODG reports limited positive evidence to support physical therapy for knee complaints. ODG specifies, "It is important for the physical therapy provider to document the patient's progress so that the physician can modify the care plan, if needed. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions (e.g., joint range-of-motion and weight-bearing limitations, and concurrent illnesses)... A physical therapy consultation focusing on appropriate exercises may benefit patients with OA, although this recommendation is largely based on expert opinion." Additionally, ODG quantifies the number of sessions for Arthritis (Arthropathy, unspecified) (ICD9 716.9): "Medical treatment: 9 visits over 8 weeks Post-injection treatment: 1-2 visits over 1 week Post-surgical treatment, arthroplasty, knee: 24 visits over 10 weeks" MTUS guidelines further state, "Initial course of therapy" means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section." Medical records provided the last surgical intervention was in 2013, the treating physician has not provided objective findings that indicate functional deficits of the thoracic spine. The treating physician does indicate that this patient has signs and symptoms of a

potential meniscus tear and the previous reviewer modified the request to 2 visits per week for 3 weeks for physical therapy of knee. As such, the request for 12 additional physical therapy sessions to the thoracic spine and right knee is not medically necessary.