

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0037037 | | |
| Date Assigned: | 06/25/2014 | Date of Injury: | 04/23/2007 |
| Decision Date: | 03/11/2015 | UR Denial Date: | 03/06/2014 |
| Priority: | Standard | Application Received: | 03/27/2014 |

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 59 year-old female Line Cook sustained an injury on 4/23/07 from a slip and fall while employed by [REDACTED]. Request(s) under consideration include Physical Therapy of the right knee. Report of 1/29/14 from the provider noted patient with chronic right shoulder, neck and coccygeal region pain along with right knee pain. Exam of the right shoulder showed restricted painful range of motion; tenderness on palpation over the greater tuberosity of humerus; positive impingement sign. Diagnoses included cervical disc lesion; lumbar disc herniation with radiculitis; right shoulder tendinitis and impingement; bilateral knee sprains; insomnia/anxiety/depression. Treatment included PT to decrease pain, restore function to focus on strength training and increasing range of motion. There has been previous orthopedic utilization review for right knee arthroscopy dated 2/24/10 noting lack of objective clinical findings and MRI report correlating with any definitive necessary surgical intervention to support for arthroscopy request. There is no surgical history provided nor is there any report of previous PT rendered with functional improvement. Current request(s) for Physical Therapy of the right knee was non-certified on 3/6/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy of the right knee: 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), Knee Chapter

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

Decision rationale: This 59 year-old female Line Cook sustained an injury on 4/23/07 from a slip and fall while employed by [REDACTED]. Request(s) under consideration include Physical Therapy of the right knee. Report of 1/29/14 from the provider noted patient with chronic right shoulder, neck and coccygeal region pain along with right knee pain. Exam of the right shoulder showed restricted painful range of motion; tenderness on palpation over the greater tuberosity of humerus; positive impingement sign. Diagnoses included cervical disc lesion; lumbar disc herniation with radiculitis; right shoulder tendinitis and impingement; bilateral knee sprains; insomnia/anxiety/depression. Treatment included PT to decrease pain, restore function to focus on strength training and increasing range of motion. There has been previous orthopedic utilization review for right knee arthroscopy dated 2/24/10 noting lack of objective clinical findings and MRI report correlating with any definitive necessary surgical intervention to support for arthroscopy request. Current request(s) for Physical Therapy of the right knee was non-certified on 3/6/14. There is no surgical history provided nor is there any report of previous PT rendered with functional improvement. Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy. 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. There is unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. It is unclear how many PT sessions the patient has received or what functional outcome was benefited if any. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the patient has received prior sessions of PT without clear specific functional improvement in ADLs, work status, or decrease in medication and utilization without change in neurological compromise or red-flag findings to support further treatment. The Physical Therapy of the right knee is not medically necessary and appropriate.