

Case Number:	CM15-0015692		
Date Assigned:	02/03/2015	Date of Injury:	10/19/2013
Decision Date:	03/27/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	01/27/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 69 year old male who sustained an industrial injury to his left hand, arm and shoulder while working on a cement truck when his glove got caught in the mixer crushing the dorsum of the left hand on October 19, 2013. The injured worker underwent open reduction internal fixation of the left 4th metacarpal shaft the day of the injury. On August 26, 2014, the injured worker underwent arthroscopic capsular release with coplanar claviculoplasty. Removal of hardware and MP capsulotomy and extensor tendon release digits 2 through 5 was performed on October 21, 2014. The injured worker was diagnosed with adhesive capsulitis, left bicipital tenosynovitis and left hand crush injury. According to the primary treating physician's progress report on January 13, 2015, the injured worker continues to experience pain with range of motion. On physical examination the injured worker demonstrated active adduction to 170 degrees and active forward flexion to 170 degrees with painful arc motion and an internal rotation contracture of 15-20 degrees. There was marked pain over the proximal bicipital groove. Current medications consist of Naproxen, Norco and Sonata. Treatment modalities consist of 32 physical therapy sessions completed, home exercise program, ice, medication and a cortisone injection to the left shoulder on January 13, 2015. The injured worker is on temporary total disability (TTD). The treating physician requested authorization for additional post-op physical therapy, twice weekly for 4 weeks, left shoulder, Qty: 8. On January 26, 2015 the Utilization Review denied certification for additional post-op physical therapy, twice weekly for 4 weeks, left shoulder, Qty: 8 as in excess of the recommended guidelines. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS), Post-Surgical Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional post-op physical therapy, twice weekly for 4 weeks left shoulder per 1/14/15 form: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: According to MTU According to MTUS guidelines, Physical Medicine is "Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)"There is no documentation of objective findings that the patient condition needed physical therapy instead of home exercise. The patient underwent several physical therapy sessions without documentation of clear benefit. Therefore additional post-op physical therapy, twice weekly for 4 weeks left shoulder is not medically necessary.