MAXIMUS Federal Services

Case Number:	CM15-0063489		
Date Assigned:	04/09/2015	Date of Injury:	06/07/2013
Decision Date:	05/18/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	04/03/2015

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 42 year old female who sustained a work related injury June 7, 2013. According to a primary treating physician's progress report, dated February 25, 2015, the injured worker presented for re-evaluation for a pain in the right wrist and left knee. There is point tenderness to palpation, clicking and popping about the scapholunate ligament, right wrist with increased pain upon extension. Examination of the left knee reveals quadriceps muscle atrophy with decreased tone, popping and clicking about the patellofemoral joint and patellofemoral malalignment. Diagnoses are right wrist, scapholunate ligament tear; left knee, chondromalacia patellae with patellofemoral malalignment with quadriceps muscle atrophy and weakness. Treatment plan included continue anti-inflammatory medications as needed and request for authorization for physical therapy with ultra sound massage, and therapeutic exercise 2 x 6 for the right wrist and left knee. The issue for review; physical therapy two times a week for six weeks, right wrist, quantity, 12.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Two Times a Week for Six Weeks Right Wrist Quantity 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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 physical therapy two times a week for six weeks, right wrist, quantity: 12 is not medically necessary and appropriate.