

Case Number:	CM14-0143584		
Date Assigned:	09/12/2014	Date of Injury:	03/12/2014
Decision Date:	10/07/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	09/04/2014

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 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 34 year-old patient sustained an injury on 3/12/14 from a slip and fall while employed by [REDACTED]. Request(s) under consideration include Physical therapy twice per week for six weeks for the right knee and Physical therapy twice per week for 6 weeks for the right shoulder. Diagnoses list shoulder joint pain. The patient reported neck, right shoulder, low back, right knee, and right ankle pain. Conservative care has included physical therapy, right knee immobilizer, shoe/boot, ankle splints, crutches, lumbar brace, medications, and modified activities/rest. Medications list Tramadol/APAP, Ketamine cream, Diazepam (from other MD). MRI of right shoulder dated 6/10/14 showed rotator cuff tendinosis at supraspinatus/infraspinatus; mild AC joint degenerative change; minimal labral fraying and biceps tenosynovitis. Unofficial report from provider noted MRI of right knee with small anterior horn junction and medial meniscal tear. Report of 7/16/14 from the provider noted ongoing symptom complaints in above joints. Exam showed diffuse 4/5 muscle weakness in right upper extremity; using right knee immobilizer, diffuse 4/5 muscle weakness in right lower extremity throughout with pain on movement. The request(s) for Physical therapy twice per week for six weeks for the right knee and Physical therapy twice per week for 6 weeks for the right shoulder were non-certified on 8/5/14 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 twice per week for six weeks for the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Physical Medicine Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 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 (range of motion), strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, 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. 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. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. Therefore, Physical therapy twice per week for six weeks for the right knee is not medically necessary and appropriate.

Physical therapy twice per week for 6 weeks for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical Therapy Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

Decision rationale: The patient has received physical therapy treatment; 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 work 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. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. Therefore, Physical therapy twice per week for 6 weeks for the right shoulder is not medically necessary and appropriate.

