

Case Number:	CM13-0015190		
Date Assigned:	10/07/2013	Date of Injury:	10/02/2012
Decision Date:	02/03/2014	UR Denial Date:	08/09/2013
Priority:	Standard	Application Received:	08/22/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, and is licensed to practice in Texas. 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 physician 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:

The patient was a 56 year old male with complaints of a back injury, leg pain, knee pain and hip pain. The patient participated in 8+ sessions of physical therapy to his right lower extremity. The patient had improvement in condition noted with no pain to his right leg upon examination on 08/01/2013

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy (PT) one (1) time a week for six (6) weeks right leg and right foot: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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

Decision rationale: The request for physical therapy (PT) one (1) time a week for six (6) weeks for the right leg and right foot non-certified. The patient participated in physical therapy sessions with improvement to condition noted. However, the patient had no objective findings of functional improvement. The patient had no objective findings of deficits in flexibility, strength, endurance, function submitted for review. Physical therapy is recommended for restoring flexibility, strength, endurance, function, and range of motion by guidelines. Given the

information submitted for review the request for physical therapy (PT) one (1) time a week for six (6) weeks right leg and right foot non-certified.