

Case Number:	CM13-0027387		
Date Assigned:	11/22/2013	Date of Injury:	07/25/2012
Decision Date:	02/20/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	09/20/2013

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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 is a 38-year-old male who reported an injury on 07/25/2011. The patient is diagnosed with a lumbosacral sprain and strain, right knee sprain and strain, cervical sprain and strain, left wrist sprain and strain, and headaches. The patient was seen by [REDACTED] on 08/09/2013. The patient reported 4-6/10 low back pain with 3/10 right knee pain and 4/10 neck pain. The physical examination revealed tenderness to palpation. The patient also demonstrated full, active knee range of motion in stability testing. The patient demonstrated slightly restricted lumbar range of motion and hypomobile subluxations at C1 and L5. Treatment recommendations included 12 sessions of physical therapy for the low back and right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2x week x 6 week's lumbar and right knee: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Physical Therapy.

Decision rationale: The California Medical Treatment utilization Schedule (MTUS) guidelines state 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. The guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. As per the clinical documentation submitted, the patient has previously completed a course of physical therapy. There is no documentation of significant functional deficits to support the request for skilled physical medicine treatment. The patient demonstrates full, active right knee range of motion and only slightly restricted lumbar range of motion. Documentation of a previous course of treatment with total duration and efficacy was not provided for review. Based on the clinical information received, the request is non-certified.