

<b>Case Number:</b>	CM13-0041577		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	09/13/2011
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	10/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/11/2013

### 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 male sustained an injury on 9/13/11 while employed by [REDACTED]. Request under consideration include Physical Therapy 2 times a week for 6 weeks to the left lower extremity. The patient was carrying some cases walking on some steps and felt immediate pain in the left calf. Conservative care has included medication and physical therapy. Orthopedic evaluation recommended walking boot and crutches with possible surgery if not improved. Report of 5/8/13 from the provider noted patient with left calf/knee and ankle pain with locking and giving way of the knee. Exam noted localized tenderness over the mid third of the calf and slight tenderness at the musculotendinous junction of the Achilles; resistance to DF produced pain; gastrocsoleus tenderness. Diagnoses included Achilles rupture and left meralgia paresthesia. Report of 8/28/13 noted continued chronic pain; EMG/NCS showed meralgia paresthetica. Request for PT above was modified on 10/7/13 from 12 to 8 sessions 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 2 TIMES A WEEK FOR 6 WEEKS TO THE LEFT LOWER EXTREMITY:** Upheld

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

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

**Decision rationale:** This male sustained an injury on 9/13/11 while employed by [REDACTED]. Request under consideration include PHYSICAL THERAPY 2 TIMES A WEEK FOR 6 WEEKS TO THE LEFT LOWER EXTREMITY. The patient was carrying some cases walking on some steps and felt immediate pain in the left calf. Conservative care has included medication and physical therapy. Orthopedic evaluation recommended walking boot and crutches with possible surgery if not improved. Report of 5/8/13 from the provider noted patient with left calf/knee and ankle pain with locking and giving way of the knee. Exam noted localized tenderness over the mid third of the calf and slight tenderness at the musculotendinous junction of the Achilles; resistance to DF produced pain; gastrocsoleus tenderness. Diagnoses included Achilles rupture and left meralgia paresthesia. Report of 8/28/13 noted continued chronic pain; EMG/NCS showed meralgia paresthetica. Request for PT above was modified on 10/7/13 from 12 to 8 sessions citing guidelines criteria and lack of medical necessity. 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 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 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received extensive therapy sessions with recent 8 visits without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up and the patient has been instructed on a home exercise program for this 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 2 TIMES A WEEK FOR 6 WEEKS TO THE LEFT LOWER EXTREMITY is not medically necessary and appropriate.