

Case Number:	CM13-0056866		
Date Assigned:	12/30/2013	Date of Injury:	07/17/2009
Decision Date:	05/21/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/24/2013

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, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in Maryland. 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:

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 42 year old female with a date of work injury 7/17/09. Her diagnoses include 1) Strain/sprain of the cervical spine superimposed on 2 mm posterior disc bulge at C4-5, per MRI of 6/09/11 2) Strain/sprain of the lumbar spine, rule out herniated nucleus pulposus 3) Strain/sprain of the right knee with chondromalacia. There is a request for physical therapy two times a week for three weeks to the cervical spine, lumbar spine and right knee. There is documentation that an April 3, 2013 MRI scan of the cervical spine revealed mild disc desiccation at C2-3, C4-5 and C5-6, as well as 2mm disc bulges at C4-5 and C5-6. The lumbar spine MRI scan showed a 2,5 mm disc bulge at L4-S with bilateral facet arthrosis and a 4 mm disc protrusion with bilateral facet arthrosis and mild bilateral neural foraminal narrowing at L5-S1. An EMG/NCV study of the bilateral upper and lower extremities done on April 11, 2013 was normal. There is an 8/8/13 medical legal report that states that on July 17, 2013 the provider saw the patient due to a flare-up of her symptoms. She has already been declared permanent and stationary and reached medical improvement by the AME on June 7, 2011. Her future medical care included short courses of therapy for exacerbations of her symptoms. She stated that her neck pain was rated 5-7 on a scale of 1-10, ten being most severe, which radiates up to the neck to the left occipital and parietal regions and to the left eye There is also radiating pain down the left arm to the ring and middle fingers. Her low back pain was rated 5 to 8/10 with radiation down the right buttock and lower extremity posteriorly to the right heel with numbness and tingling in the same area as the pain, and right big toe. Her right knee pain was rated 5-8/10. Examination of the cervical spine reveals pain to palpation at the cervical spine, upper trapezius, paravertebral muscles and upper thoracic spine on the left. Cervical compression

is positive on the left. Sensory and motor power testing was normal in the upper extremities. There is decreased range of motion in the cervical spine. Examination of the lumbar spine reveals tenderness to palpation at the left thoracic and lumbar paravertebral muscles, spinous processes, sacroiliac joints and sciatic notch. Walking on tiptoes produces pain in the lumbar spine and right knee, walking on heels produces pain in the right buttock and right heel. The patient cannot perform a full squat. Sensation and motor power testing was normal in the lower extremities. Examination of the knees reveals medial more than lateral joint line tenderness on the right. McMurray's is positive on the medial joint line on the right. Patellar grinding is 1+ on the right. There is decreased range of motion in lumbar range of motion. The records indicate that the patient was authorized 6 physical therapy visits on 8/19/13. A prior Utilization review on 10/31/13 denied additional PT stating that in the medical report dated 9/5/13 there are no physical examination findings pertinent to the right knee. Likewise, the report indicates that the patient has demonstrated a good understanding of HEP. A 10/17/13 PT progress report indicates that the patient has a 15% improvement overall but has trouble still with squatting, kneeling, and standing. There are objective improvements in knee extension range of motion, walking, standing, and sitting tolerance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy twice a week for three weeks for cervical/lumbar spine and right knee:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints.

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

Decision rationale: Physical Therapy twice a week for three weeks for cervical/lumbar spine and right knee is not medically necessary as written. The documentation submitted that patient has progressed in walking, standing and sitting tolerance in PT as well as has a 15% improvement overall on the prior 6 PT sessions. However, the request for an additional 6 sessions of PT would bring the most recent therapy visits to 12 which exceed the guidelines recommendations of up to 10 visits for patient's condition. (Myalgia and myositis, unspecified): 9-10 visits over 8 weeks and Neuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeks) Therefore, the request as written for physical therapy twice a week for 3 weeks is not medically necessary as written.