

Case Number:	CM14-0139636		
Date Assigned:	09/05/2014	Date of Injury:	03/29/2014
Decision Date:	11/05/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/28/2014

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 patient sustained an injury on 3/29/14. The request under consideration is for Physical therapy. Diagnoses include myofascial pain, depression, insomnia, cervical disc disorder, lumbar disc disorder, cervical pain, lumbar pain, left knee pain, and left ankle pain. Conservative care has included medications, therapy, and modified activities/rest. Report of 7/9/14 from the chiropractic provider noted the patient with ongoing cervical and lumbar spine with loss of range and spasms; left knee and ankle pain with spasm and loss of motion. Exam showed cervical and lumbar spine with limited range and pain on palpation; limited painful left knee and ankle range; left knee swelling; diffuse sensory loss of upper extremities and hands. The request for Physical therapy was modified from quantity of 12 sessions to 6 sessions on the Utilization Review dated 8/8/14, 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 (12-sessions, 2 times a week for 6 weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg; Physical Medicine, Low Back; Physical Therapy, Neck & Upper Back; Physical Therapy, Ankle & Foot; Physical Therapy

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

Decision rationale: Physical therapy (PT) 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 evidence of clear, measurable progress with the PT treatment already rendered, including milestones of increased range of motion (ROM), strength, and functional capacity. A review of submitted physician reports shows no evidence of functional benefit; but rather, 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 therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of an acute flare-up, new injuries, or a change in symptoms or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic 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. This request for physical therapy is not medically necessary and appropriate.