

<b>Case Number:</b>	CM14-0159693		
<b>Date Assigned:</b>	10/03/2014	<b>Date of Injury:</b>	09/19/2011
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 Internal Medicine, has a subspecialty in Nephrology, 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 is a 62-year-old male with a 9/19/11 date of injury. He was loading a truck when suddenly someone moved the truck and he fell, hitting his left knee on one of the bars of the truck. According to the most recent report provided for review, dated 4/16/14, the patient complained of constant neck pain, constant bilateral shoulder pain, constant left hip pain, constant low back pain, and constant left knee pain. Objective findings: tenderness to palpation with limited and painful range of motion and positive orthopedic evaluation to the left knee, lower back, left hip, neck, and right and left shoulder; neurological findings in upper extremities, decreased sensation at C5-6 and L5-S1 on left. Diagnostic impression: lumbar discopathy with radiculopathy, shoulder tendinosis with impingement, cervical sprain/strain, left hip strain/strain. Treatment to date: medication management, activity modification, physical therapy, acupuncture, injections. A UR decision dated 9/16/14 denied the request for physical therapy. There is no documentation provided describing the specific number of visits that have been rendered thus far, as well as no information describing specific signs of objective function improved as a result of the previous physical therapy rendered to support additional therapy at this time.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Rehab/PT 2-3x/month as needed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Physical Therapy page(s) 98-99; 9792.22 General Approaches Page(s): 98-99; GENERAL APP. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function Chapter 6, page 114

**Decision rationale:** CA MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Physical Medicine Guidelines - Allow for fading of treatment frequency. However, in this case, the patient has had prior physical therapy treatment. It is unclear how many sessions he has previously completed. There is no documentation of functional improvement or gains in activities of daily living from the prior physical therapy sessions. In addition, it is unclear why the patient has not been able to transition to an independent home exercise program at this time. Furthermore, the area for treatment, duration of treatment, and number of sessions were not noted in this request. Therefore, the request for Physical Rehab/PT 2-3x/month as needed was not medically necessary.