

Case Number:	CM14-0170603		
Date Assigned:	10/23/2014	Date of Injury:	01/15/2008
Decision Date:	12/03/2014	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	10/15/2014

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 Occupational Medicine, 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:

Patient is a 56 year-old female with date of injury 01/16/2008. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 10/13/2014, lists subjective complaints as pain in the low back and left knee. Objective findings: Examination of the left knee revealed joint line tenderness medially and laterally. Ligaments were stable mediolaterally. There was trace laxity in the anteroposterior plane. Range of motion was limited in extension and flexion. Examination of the lumbar spine revealed restricted range of motion. Straight leg raising tests were negative bilaterally. Diminished sensation to the L3-S1 dermatomes. An MRI of the lumbar spine performed on 07/01/2014 was unremarkable. It was noted that the patient has undergone previous sessions of physical therapy, but the date and number of visits was not documented. Diagnosis: 1. Chronic lower back and referred leg pain syndrome 2. Possible referred pain secondary to L4-L5 and L5-S1 lateral recess stenosis 3. L5-S1 degenerative disc disease and facet arthropathy 4. Status post revision left total knee arthroplasty 5. Status post left shoulder rotator cuff repair 6. Status post left hip arthroscopic labral repair 7. History of cervical sprain with possible spondylosis and left upper extremity referred pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy (left Knee, Lumbar) 1 x 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 58-60.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that 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. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. Physical Therapy (left Knee, Lumbar) 1 x 6 weeks is not medically necessary.