

<b>Case Number:</b>	CM14-0075307		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	04/22/2014
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	05/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/23/2014

### 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 & 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 40 year-old patient sustained an injury on 4/22/14 when a patient weight approximately 110 pounds landed over the claimant while employed by [REDACTED]. Request under consideration include Physical Therapy Thoracic, Lumbar, Right Wrist, Left Knee-Ankle 2x Week x 4 Weeks (12). Report of 5/1/14 from the provider noted the patient with headaches, back, right hand pain as well as left leg and knee pain. Exam showed antalgic gait favoring left lower extremity; TTP of thoracic spine; spasm and trigger points in bilateral upper and mid thoracic region; decreased range of motion; tenderness to palpation spinal processes L2-L5 in bilateral paraspinal muscles; spasms and decreased range; positive SLR at right 30/ left 36 degrees; right wrist swelling; TTP of dorsal, palmar, ulnar, radial aspects; positive Phalen's; right wrist/hand with 4/5 motor strength; decreased sensation over right hand; left knee swelling, TTP diffusely about patella, condyle; decreased range and positive McMurray/Lachman's; decreased motor strength at left knee of 3/5. The patient to remain temporarily partially disabled (unclear if working). Conservative care has included medications, diagnostics, therapies, lumbosacral brace, right wrist thumb Spica brace, left knee sleeve, Interferential unit, Hot/cold unit, and modified activities/rest. Medications list Motrin, Fluriflex, and TG hot topical compounds. Diagnoses include thoracic and lumbosacral musculoligamentous strain/sprain; lumbosacral region contusion; right wrist sprain/strain rule out internal derangement; rule out right wrist fracture/ contusion; left knee strain/sprain rule out left knee internal derangement/ meniscal tear; and left ankle strain/sprain. The request for Physical Therapy Thoracic, Lumbar, Right Wrist, Left Knee-Ankle 2x Week x 4 Weeks was partially-certified for quantity of #6 sessions on 5/15/14 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 Thoracic, Lumbar, Right Wrist, Left Knee-Ankle 2x Wk x 3 Wks (6):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy. Decision based on Non-MTUS Citation ACOEM GUIDELINES: Low Back Complaints, Forearm, Wrist, and Hand Complaints, Knee Complaints, Ankle and Foot Complaints (Initial care) and Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99, Physical Medicine Guidelines -Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks Page(s): 98-99.

**Decision rationale:** 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 therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has not functionally improved from treatment rendered. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional change. The Physical Therapy Thoracic, Lumbar, Right Wrist, Left Knee-Ankle 2x Week x 3 Weeks (6) is not medically necessary.