

<b>Case Number:</b>	CM14-0099188		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	06/19/2008
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	06/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/27/2014

### 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 is a 62 year old female who suffered an industrial related injury on 6/19/07. A physician's report dated 6/5/14 noted the injured worker had complaints of bilateral shoulder pain, cervical spine pain, low back pain that radiated to bilateral legs, and bilateral knee pain. Diagnoses included segmental instability spondylolisthesis at L4-5, herniated Lumbar disc L4-5 and L5-S1 with radiculopathy. The injured worker was post 3 lumbar epidural steroid injections and laminectomy and foraminotomy in 2009. Other diagnoses included bilateral knee strain/sprain, cervical spine strain/sprain, and bilateral shoulder strain/sprain, bilateral elbow strain/sprain with medial epicondylitis, bilateral wrist strain/sprain, gastritis, diverticulitis, anxiety, depression, and fibromyalgia. The injured worker underwent left knee surgery in 2008. The treatment plan noted the injured worker would continue physical therapy 2 times per week for 6 weeks for the lumbar spine and left knee. Medications including Cymbalta, Ambien, and Ultram were refilled. The work status noted on the physician's report dated 9/11/14 was permanent and stationary. On 6/9/14 the utilization review (UR) physician denied the request for 12 physical therapy visits for the left knee. The UR physician noted that based on the remoteness of the surgery, the fact the injured worker had been determined to be at maximum medical improvement, and the lack of new clinical indications for additional physical therapy; the request was not medically necessary. The UR physician also noted there was a lack of documentation regarding the number of physical therapy treatments and any functional improvement achieved.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy (PT) for the left knee x12: Upheld**

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

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

**Decision rationale:** This is a 62 year old female who suffered an industrial related injury on 6/19/07. Diagnoses included segmental instability spondylolisthesis at L4-5, herniated Lumbar disc L4-5 and L5-S1 with radiculopathy. The injured worker was post 3 lumbar epidural steroid injections, laminectomy and foraminotomy in 2009 and left knee surgery in 2008. Other diagnoses included bilateral knee strain/sprain, cervical spine strain/sprain, and bilateral shoulder strain/sprain, bilateral elbow strain/sprain with medial epicondylitis, bilateral wrist strain/sprain, gastritis, diverticulitis, anxiety, depression, and fibromyalgia. The patient continues to treat for chronic complaints of bilateral shoulder pain, cervical spine pain, low back pain that radiated to bilateral legs, and bilateral knee pain. The work status noted on the physician's report dated 9/11/14 was permanent and stationary. 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 range of motion (ROM), strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional 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 significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom 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. The Physical Therapy for the left knee x12 is not medically necessary and appropriate.