

<b>Case Number:</b>	CM14-0124858		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	08/20/2003
<b>Decision Date:</b>	01/27/2015	<b>UR Denial Date:</b>	07/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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 Rehab, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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:

Per the UR, the injured worker is a 57 year old female who suffered a work related injury on 08/20/03 when her chair tipped over backwards. She suffered injury to her back bilateral shoulders and bilateral knees. Treatment has included lumbar facet radiofrequency ablation. Per the physician notes from 07/29/14, she complains of chronic low back and right knee pain. She reports an increase in pain while doing physical therapy for the right knee. She has only had one session. She has not started physical therapy of the back yet. She reports that medication help to reduce some pain and allow for greater function. She has received a lumbar epidural steroid injection which did provide some pain relief. Examination showed tenderness to palpation at the lumbosacral junction, and decreased range of motion to the lumbar spine. Sensation is decreased to light touch on the left lower extremity. The right knee is noted to have tenderness to palpation over the anterior knee joint. Diagnoses include degeneration lumbar lumbosacral disc, lumbago, and pain in the joint lower leg right knee. The requested treatment is 12 additional Physical therapy sessions. This treatment was denied by the Claims Administrator on 07/17/2014 and was subsequently appealed for Independent Medical Review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy two times a week for six weeks in treatment QTY:12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

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

**Decision rationale:** Physical Therapy two times a week for six weeks in treatment QTY:12 is not medically necessary as written per the MTUS Chronic Pain Medical Treatment Guidelines. The request exceeds the recommended number of visits for this condition which is up to 10. There are no extenuating circumstances documented that would necessitate exceeding those recommendations therefore the request for physical therapy two times a week for six weeks is not medically necessary as written.