

Case Number:	CM14-0197259		
Date Assigned:	12/05/2014	Date of Injury:	08/19/2013
Decision Date:	01/15/2015	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	11/24/2014

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 48 year-old patient sustained an injury on 8/19/13 while employed by [REDACTED]. Request(s) under consideration include Physical therapy for the lumbar spine as outpatient, twice weekly for six weeks. Diagnoses include right shoulder rotator cuff tendinitis/strain; multilevel lumbar disc disease; left knee sprain/strain and Degenerative changes without tear; memory loss and headaches; and high blood pressure. Conservative care has included medications, therapy, sleep study, and modified activities/rest. The patient continues to treat for chronic ongoing low back, right shoulder, and left knee/hip pain rated at 1-4/10. The patient is currently working and wearing left knee brace. Report of 10/14/14 from the provider noted unchanged exam findings of limited lumbar range with tenderness; positive SLR and diminished sensation diffusely at L4, L5, and S1 with normal strength and sensation on right; symmetrical 2+ DTRs; right shoulder with tenderness over AC joint and slight decreased 4+/5 strength in flexion and extension; left knee with swelling and decreased flex of 120 degrees and extension 0 degrees with medial joint line tenderness. Treatment included continuing medication of Voltaren cream and therapy. The request(s) for Physical therapy for the lumbar spine as outpatient, twice weekly for six weeks was non-certified on 10/24/14 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 for the lumbar spine as outpatient, twice weekly for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), and Goodman and Gilman's The Pharmacological Basis of Therapeutics, 12th Edition, McGraw-Hill, 2010, as well as the Physician's Desk Reference, 68th Edition

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

Decision rationale: According to guidelines, 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 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 lumbar spine as outpatient, twice weekly for six weeks is not medically necessary and appropriate.