

Case Number:	CM14-0198327		
Date Assigned:	12/08/2014	Date of Injury:	08/31/1999
Decision Date:	01/20/2015	UR Denial Date:	11/11/2014
Priority:	Standard	Application Received:	11/25/2014

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 patient sustained an injury on 8/31/1999 while employed by [REDACTED]. Request(s) under consideration include Additional physical therapy twice a week for 6 weeks, lumbar, bilateral knees. Diagnoses include left knee strain s/p right knee arthroscopy on 10/28/10 and lumbar radiculopathy s/p lumbar surgery in July 2000; cervical facet arthropathy; and possible left shoulder rotator cuff disorder. Conservative care has included medications, therapy, manipulation, injections, knee brace, LESI at L5-S1, Extracorporeal shockwave treatment, and modified activities/rest. Medications list Mobic, Tramadol, Omeprazole, Topicals, and Lyrica. Report of 10/28/14 from the provider noted the patient with chronic ongoing lower back and bilateral knee pain symptoms; patient noted previous therapy helped with increasing mobility and function and would like for treatment option. Exam showed unchanged findings of lumbar spine with tenderness; full functional range of hip, knees (0-110 degrees), and ankles; intact sensation; symmetrical DTRs, positive SLR on right (nonspecified); and weakness of left thigh flexion. The request(s) for Additional physical therapy twice a week for 6 weeks, lumbar, bilateral knees was modified for 4 sessions on 10/3/14 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:

Additional physical therapy twice a week for 6 weeks, lumbar, bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 14 Ankle and Foot Complaints, Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

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

Decision rationale: This patient sustained an injury on 8/31/1999 while employed by [REDACTED]. Request(s) under consideration include Additional physical therapy twice a week for 6 weeks, lumbar, bilateral knees. Diagnoses include left knee strain s/p right knee arthroscopy on 10/28/10 and lumbar radiculopathy s/p lumbar surgery in July 2000; cervical facet arthropathy; and possible left shoulder rotator cuff disorder. Conservative care has included medications, therapy, manipulation, injections, knee brace, LESI at L5-S1, Extracorporeal shockwave treatment, and modified activities/rest. Medications list Mobic, Tramadol, Omeprazole, Topicals, and Lyrica. Report of 10/28/14 from the provider noted the patient with chronic ongoing lower back and bilateral knee pain symptoms; patient noted previous therapy helped with increasing mobility and function and would like for treatment option. Exam showed unchanged findings of lumbar spine with tenderness; full functional range of hip, knees (0-110 degrees), and ankles; intact sensation; symmetrical DTRs, positive SLR on right (nonspecified); and weakness of left thigh flexion. The request(s) for Additional physical therapy twice a week for 6 weeks, lumbar, bilateral knees was modified for 4 sessions on 10/3/14. 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 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 9-10 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 Additional physical therapy twice a week for 6 weeks, lumbar, bilateral knees are not medically necessary and appropriate.