

<b>Case Number:</b>	CM15-0106027		
<b>Date Assigned:</b>	06/10/2015	<b>Date of Injury:</b>	08/25/2014
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 50-year-old male, who sustained an industrial injury on 08/25/2014. According to an initial orthopedic evaluation dated 04/08/2015, the injured worker was involved in a crush injury of his lower extremities. Treatment has included medications and physical therapy. The cervical spine was non-tender to palpation without step offs. He had no pain with range of motion of the shoulders, elbows, wrists, and digits without any soft tissue swelling or deformity. He was neurovascularly intact distally in the bilateral upper extremities. Compartments were soft. Skin was intact. The thoracolumbar spine was non-tender to palpation without any step offs. The pelvis was stable and non-tender to anterior posterior and lateral compression. The right lower extremity had a well-healed divot over the medial aspect of the right thigh. He had no redness noted. His medial and lateral joint lines were non-tender to palpation. He had negative McMurray's sign. The knee was stable to both varus and valgus stress as well as anterior and posterior stress. He had negative Lachman's, negative anterior drawer, and negative posterior drawer all with firm endpoints. The remainder examination of the right lower extremity was unremarkable. He was noted to have full range of active and passive motion of the knee, ankle and toes. He was neurovascularly intact distally in the right lower extremity. Examination of the left lower extremity demonstrated no pain with range of motion of the hip, knee, ankle and subtalar joint without any soft tissue swelling or deformity. He was neurovascularly intact distally in the left lower extremity. Compartments were soft. Skin was intact. Assessment included right greater than left thigh crush injury, right sartorius muscle injury and left patellofemoral syndrome. The treatment plan included physical therapy,

Naprosyn and modified duties. Currently under review is the request for physical therapy two times a week for six weeks for the right thigh (12 sessions).

### **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 for the right thigh quantity : 12 sessions:**  
Upheld

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

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

**Decision rationale:** According to MTUS guidelines, Physical Medicine is "Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)" There is no documentation of objective findings that support musculoskeletal dysfunction requiring more physical therapy sessions. There is no documentation of the outcome of previous physical therapy sessions and home exercise. There is no documentation supporting additional physical therapy sessions. Therefore Physical therapy two times a week for six weeks for the right thigh quantity: 12 sessions is not medically necessary.