

Case Number:	CM15-0142328		
Date Assigned:	08/03/2015	Date of Injury:	09/03/2014
Decision Date:	08/31/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/22/2015

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 59-year-old female, who sustained an industrial injury on September 3, 2014, incurring left knee injuries after falling on steps. She was diagnosed with a tibia and fibular fracture. Treatments included pain medications, physical therapy, home exercise program, and activity modifications. She underwent a surgical open reduction internal fixation of the left tibial plateau. Currently, the injured worker complained of continued left foot pain and swelling. She noted lower back pain radiating down the thigh into her foot with numbness and tingling in the toes. She had limited range of motion in extension of the left knee and feelings of instability. Electromyography studies revealed peroneal neuropathy below the left knee. The treatment plan that was requested for authorization included eight sessions of physical therapy for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 sessions of physical therapy, lumbar: 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 in this case. The patient most recent evaluation dated on June 2015, demonstrated that the patient was complaining of left foot pain and numbness, with left knee range of motion 0-135 degree. There is no clear evidence of a major musculoskeletal deficit requiring supervised physical therapy. Home exercise should be tried first before considering physical therapy. There is no justification for the prescription of 8 sessions of physical therapy without documentation of the efficacy of the first visits. Therefore, 8 sessions of physical therapy, lumbar is not medically necessary.