

Case Number:	CM15-0202414		
Date Assigned:	10/19/2015	Date of Injury:	04/21/1997
Decision Date:	12/02/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	10/14/2015

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 York
 Certification(s)/Specialty: Anesthesiology

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 62 year old female, who sustained an industrial injury on 4-21-1997. The injured worker is undergoing treatment for: status post failed knee replacement, osteomyelitis of knee, anxiety, yeast infection, low back pain; status post candida abicans knee infection, clostridium difficile, shoulder pain, and lumbar radiculopathy. On 8-4-15, she is reported to be undergoing home physical therapy. On 8-24-15, she reported low back pain with radiation into the right leg. She is noted to have been treated in the hospital for cellulitis of the left lower extremity. Physical findings revealed resolving cellulitis of the left lower extremity, inability to stand and is wheelchair bound., cranial nerves 2-12 are intact, and left shoulder with painful range of motion. On 9-16-2015, she reported right knee pain rated 5 out of 10, right hip pain rated 6 out of 10, low back pain rated 6 out of 10, and bilateral shoulder pain rated 6 out of 10. She is noted to currently weight 252 pounds. She is reported as having difficulty with both upper extremities and getting around. There is notation of her having had home physical therapy and that "certain things would need to be done in an outpatient setting as all the needed equipment cannot be brought to her home". The records do not discuss the efficacy of the already completed home physical therapy. The treatment and diagnostic testing to date has included: wheelchair, medications, QME (10-8-15), and home physical therapy, emergency room treatment (9-24-15). Medications have included: Norco, Celebrex, Lidocaine patches, Diflucan, and Neurontin. Current work status: temporary total disability. The request for authorization is for: physical therapies for the right knee, occupational therapy for the right knee, massage therapy for the right knee, continue home physical treatment for 6 weeks for the right knee. The

UR dated 9-18-2015: non-certified the request for physical therapy 3 times a week for 12 weeks for the right knee, occupational therapy for the right knee 3 times a week for 4 weeks, massage therapy for the right knee 3 times a week for 4 weeks, and continued home physical treatment for 6 weeks for the right knee one time per week for 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, right knee, 3x12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient has had previous PT visits and there is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the additional 36 PT (3x12) sessions requested, which exceed the MTUS and ODG guidelines. Medical necessity for the additional PT visits requested has not been established. The requested services are not medically necessary.

Occupational therapy, right knee, 3 times weekly for 4 weeks, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Medicine Treatment.

Decision rationale: According to the ODG, physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy (OT), Chiropractic, and MD/DO). In this case, there is no documentation of the specific

modalities needed in occupational therapy that could not be done in a home exercise program. Medical necessity for the requested 12 sessions of OT has not established. The requested services are not medically necessary.

Massage therapy, right knee, 3 times weekly for 4 weeks, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Massage therapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Massage Therapy.

Decision rationale: Massage therapy is recommended as an option in conjunction with recommended exercise programs. Manual massage administered by professional providers has shown some proven efficacy in the treatment of acute low back symptoms, based on quality studies. Mechanical massage devices are not recommended. Massage therapy should be limited to 4-6 visits in most cases. It is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. A recent meta-analysis concluded that massage might be beneficial for patients with subacute and chronic non-specific low-back pain, especially when combined with exercises and education. When massage was compared to other active treatments, massage was similar to exercises, and massage was superior to joint mobilization, relaxation therapy, physical therapy, acupuncture, and self-care education. The beneficial effects of massage in patients with chronic low-back pain lasted at least one year after the end of the treatment. In comparing different techniques of massage, acupuncture massage produced better results than classic (Swedish) massage and Thai massage produced similar results to classic massage. The ODG recommends frequency and duration of treatment for massage therapy are the same as Manipulation: A trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. In this case, there is no documentation of a program of exercise or functional restoration to indicate that massage therapy is medically necessary at this time. The requested massage therapy is not medically necessary.

Continue home physical therapy treatment, right knee, x6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine, Home health services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Medicine Treatment.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are

instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient has had previous home PT visits and there is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the additional home physical therapy treatments (6) requested. Medical necessity for the additional home PT visits requested has not been established. The requested services are not medically necessary.