

<b>Case Number:</b>	CM15-0047296		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	01/18/2013
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 56-year-old female who sustained an industrial injury on 01/18/2013. Current diagnoses include chronic left leg/knee/calf/buttock/low back pain, vastus lateralis, gluteus medius and quadratus laborum myofascial pain, and status post blunt trauma of the left hip/leg and knee. Previous treatments included medication management. Diagnostic studies included neurological examinations, and MRI. Initial complaints included feeling something in her leg and hip rip or tear and was not able to get up on her own. Report dated 01/05/2015 noted that the injured worker presented with complaints that included chronic right knee and left lower extremity. Pain level was rated as 4-8 out of 10 on the visual analog scale (VAS). Physical examination was positive for abnormal findings. The treatment plan included physical therapy and medications. Request treatment included Physical Therapy left lower calf and right knee, 12 sessions

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy left lower calf and right knee QTY: 12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 & 9792.26 Page(s): 58-60.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that 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. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. Patient has described previous physical therapy as having "seen no change and even worsening her condition." Physical Therapy left lower calf and right knee QTY: 12 is not medically necessary.