MAXIMUS Federal Services

Case Number:	CM15-0080223		
Date Assigned:	05/01/2015	Date of Injury:	06/02/2004
Decision Date:	06/05/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/27/2015

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: Physical Medicine & Rehabilitation

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 6/2/04. The mechanism of injury is unclear. She currently (3/2/15) complains of constant neck pain extending into the upper scapular region. She also has intermittent numbness and tingling in the hands attributed to carpal tunnel syndrome and with pain intensity of 5/10. She has locking at the left knee with prolonged sitting. In addition she complains of constant low back pain (1/15/15). She takes oxycodone, gabapentin, promethazine, omeprazole, zolpidem, alprazolam. Urine drug screen (1/15/15) was consistent with current medications. Diagnoses include chronic neck pain; bilateral carpal tunnel syndrome; chronic low back pain, posterior interbody fusion at L5-S1 with hardware (4/4/05), L2-3 discitis/ osteomyelitis and drainage of spinal epidural abscess (8/25/12); chronic bilateral lower extremity cellulitis; chronic left knee pain with severe osteoarthritis; major depressive disorder. Treatments include knee-high gradient compression stockings to control edema, medications and physical therapy. In the progress note dated 1/15/15 indicates improved pain intensity and activity tolerance in response to physical therapy but her recent non-industrial pulmonary challenges have weakened her and she did not have the stamina to participate in physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 4 weeks for the lumbar spine and left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: 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 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 of June 2004. 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 Physical therapy 2 times a week for 4 weeks for the lumbar spine and left knee is not medically necessary and appropriate.