

<b>Case Number:</b>	CM15-0081475		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	04/15/2013
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 (IW) is a 63-year-old male who sustained an industrial injury on 04/15/2013. Diagnoses include right knee pain, ankle pain, mild contracture of knee, neuropathy and quadriceps tendon rupture. Treatment to date has included medications and walking program. According to the progress notes dated 4/1/15, the Injured Worker reported right knee and foot pain. A request was made for physical therapy twice weekly for six weeks for the right leg/thigh due to chronic atrophy of the quadriceps and other musculature of the right leg.

### 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 6 weeks for the right leg and thigh:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant is more than two years status post work-related injury and is being treated for right knee and foot pain. He sustained a quadriceps tendon rupture and was treated surgically. When seen, he had quadriceps atrophy with decreased knee range of motion. He had allodynia over the right foot. He was continuing a walking program. Authorization for 12 physical therapy treatment sessions for the purpose of strengthening was requested. In this case, the claimant is more than six months status post injury and, therefore, the chronic pain treatment guidelines apply. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the claimant has undergone surgery and would be expected to have already had therapy including instruction in a home exercise program. In terms of a strengthening program, this would best be performed through ongoing compliance with a home exercise program. The number of additional visits being requested is excessive both in terms of re-establishing a home exercise program and the chronic pain guidelines and would tend to promote dependence on therapy provided treatments. The request is not medically necessary.