

<b>Case Number:</b>	CM15-0087703		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	11/02/2010
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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 49 year old female who sustained an industrial injury on 11/2/2010. Her diagnoses, and/or impressions, are noted to include: bilateral wrist tenosynovitis; right and left knee contusion; and status-post right knee arthroscopy. No current imaging studies are noted. Her treatments have included physical therapy; medication management and work restrictions. Progress notes of 12/23/2014 reported feeling better following completion of her physical therapy sessions, but reported continued mild knee pain on standing and difficulty writing and grasping objects with her right hand; she also requested additional physical therapy. The objective findings were noted tenderness to the bilateral wrists/hands; weakness in grip strength; slightly restricted range-of-motion due to discomfort; decreased sensation in the right cervical spine; a mild decrease in motor strength of the right triceps/biceps; moderate swelling with mild right knee tenderness and weak quadriceps; tenderness and mild inflammation to the left knee; and tenderness with myospasm on the left lumbar spine with decreased lower extremity sensation and painful limited range-of-motion. The physician's requests for treatments were noted to include physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy treatment two (2) times a week for four (4) weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine, Physical medicine guidelines.

**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. 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 treatment two (2) times a week for four (4) weeks is not medically necessary and appropriate.