

<b>Case Number:</b>	CM14-0181452		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	05/03/2014
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 34-year-old patient sustained an injury on 5/3/14 from a fall while employed by [REDACTED]. Request(s) under consideration include Physical therapy for the lumbar spine, three times a week, for four weeks, QTY: 12 sessions. Diagnoses include Knee cruciate ligament sprain/strain status/post ACL reconstruction (June 2014) and shoulder impingement. MRI of right knee dated 5/5/14 showed ACL tear and large joint effusion. Report of 7/22/14 from the provider noted the patient with follow-up for right knee ACL reconstruction one-month post-surgery with some knee pain. Exam of right knee noted range of -10 degrees full extension and 12 degrees flexion with quad weakness. Treatment plan was for PT 2x3 to remain off work. MRI of shoulder per clinician report of 9/11/14 showed no rotator cuff tear; partial-thickness chronic bursitis. Official report of MRI on 9/10/14 had impression of SLAP lesion, supraspinatus and infraspinatus tendinosis, and mild AC joint arthropathy. Conservative care has included physical therapy (at least 12 sessions) along with modified activities/rest. X-rays of the neck, lumbar spine, and shoulder were unremarkable. Treatment plan from 8/11/14 included continued additional PT. Report of 10/6/14 noted patient to have sit work only with treatment for continued PT 2x4. Report of 11/3/14 from the provider noted unchanged restrictions of sit work with continued PT 2x4 with notation checked for "not improved significantly." The request(s) for Physical therapy for the lumbar spine, three times a week, for four weeks, QTY: 12 sessions was non-certified on 10/16/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the lumbar spine, three times A week, for four weeks, QTY: 12 sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 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 work 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 continued formal PT. 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 for the lumbar spine, three times a week, for four weeks, QTY: 12 sessions is not medically necessary and appropriate.