

<b>Case Number:</b>	CM14-0181759		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	03/18/2014
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2014

### 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 Family Medicine 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 is a 47 year old male patient who sustained a work related injury on 3/18/14. Patient sustained the injury when he was responding to an alarm while at work. The current diagnoses include bilateral plantar fasciitis, left calf strain, status post left popliteus tendon rupture, calcaneal bursitis, disk herniation in the low back with radiculopathy to the left leg, trochanteric bursitis and sacroiliac (SI) joint dysfunction on the left. Per the doctor's note dated 10/6/14, patient has complaints of pain and discomfort with his heels. Physical examination revealed pain upon palpation of bilateral medial calcaneal tubercle right greater than left, normal reflexes, negative Tinel sign, pain upon palpation of bilateral medial calcaneal, right ankle dorsiflexion 5 degrees, plantar flexion 50 degrees, Left ankle dorsiflexion with knee extended zero degrees activity, and plantar flexion 50 degrees and negative anterior drawer test. The current medication lists include Ibuprofen and compound cream. The patient has had MRI of the right foot on 05/03/14 that revealed first metatarsophalangeal joint osteoarthritis, talonavicular osteoarthritis and MRI of the left foot on 05/03/14 that revealed non-displaced fracture at the distal aspect of the proximal phalanx great toe approximately 10 mm first metatarsophalangeal joint osteoarthritis, talonavicular osteoarthritis and x-rays were normal. The past medical history includes Hypercholesterolemia. The patient's surgical history includes excision of lipoma from breast and thigh. Any surgical or procedure note related to this injury were not specified in the records provided. The patient has received 6 PT visits for this injury. The patient has used orthotics and night splints.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy times 6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Ankle and Foot

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy Page(s): 98.

**Decision rationale:** The guidelines cited above "allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." The patient has received 6 PT visits for this injury. The previous conservative therapy notes were not specified in the records provided. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Previous PT visits notes were not specified in the records provided. Per the guidelines cited, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The request for physical therapy times 6 is not fully established for this patient.