

Case Number:	CM15-0117695		
Date Assigned:	06/26/2015	Date of Injury:	04/29/1999
Decision Date:	07/27/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/18/2015

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, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 72-year-old female, who sustained an industrial injury on 4/29/1999, resulting from cumulative trauma. The injured worker was diagnosed as having osteoarthritis, unspecified whether generalized or localized, lower leg and pain in joint, lower leg. Treatment to date has included diagnostics, mental health treatment, chiropractic, physical therapy, left knee replacement in 2002 with revision in 2013, bilateral carpal tunnel releases, right knee replacement in 2010, right shoulder replacement in 2010, and medications. Currently, the injured worker complains of continued pain and discomfort to multiple body parts, rated 4/10. She reported pain to her bilateral knees, as well as her left lower back. She was doing a physical therapy program to build strength. X-rays were taken of the bilateral knees and showed no increase in osteoarthritis. The treatment plan included additional in-home physical therapy (3x4) for the lumbar spine and left knee. She was retired. Current medication regime was not detailed and therapy notes were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

In home physical therapy 3x4 weeks for lumbar spine and left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Knee section; Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, in-home physical therapy three times per week times four weeks to the lumbar spine and left knee are not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured workers working diagnoses are L/S disc herniation and left knee osteoarthritis. The date of injury is April 29, 1999. According to a September 22, 2014 progress note the injured worker received physical therapy to the left knee. There is no documentation regarding physical therapy to the lumbar spine. Subsequent documentation in a May 8, 2015 progress note (request for authorization May 21, 2015) states the injured worker has pain and discomfort in the left knee 4/10. There are no objective findings or physical examination findings of the lumbar spine and left knee. The treating provider requested additional in-home physical therapy three times per week times four weeks. The injured worker is ambulatory. There is no clinical rationale for in-home physical therapy. Additionally, there is no documentation demonstrating objective optional improvement with prior physical therapy. There are no physical examinations of the lumbar spine or left knee. There are no compelling clinical facts indicating additional physical therapy is indicated. Consequently, absent clinical documentation demonstrating objective functional improvement, objective physical examinations of the lumbar spine and left knee, prior physical therapy progress notes, total number of physical therapy sessions to date and compelling clinical facts indicating additional physical therapy is warranted, in-home physical therapy three times per week times four weeks to the lumbar spine and left knee are not medically necessary.