MAXIMUS Federal Services

| Case Number: | CM15-0121234 | | |
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| Date Assigned: | 07/01/2015 | Date of Injury: | 02/26/2012 |
| Decision Date: | 07/30/2015 | UR Denial Date: | 06/10/2015 |
| Priority: | Standard | Application Received: | 06/23/2015 |

## 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 60-year-old female, who sustained an industrial injury on 02/26/2012. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having right foot degenerative joint disease exostosis of the first metatarsophalangeal joint, over use injury of the right foot, painful gait, thoracic spine sprain/strain, lumbar spine sprain/strain with left lower extremity sciatica, right elbow sprain/strain/contusion, left hip bursitis, left knee sprain/strain and internal derangement, status post left shoulder surgery, and left wrist ganglion cyst with possible tear of the triangular ligament. Treatment and diagnostic studies to date has included laboratory studies, medication regimen, home exercise program, above noted procedure, status post left foot surgery, and post-operative physical therapy. In a progress note dated 05/15/2015 the treating physician reports complaints of pain to the left wrist, pain to the lumbar spine with pain to the left lower extremity, sharp pain to the left knee pain with the knee giving out, pain to he left hip, and pain to the right foot. The injured worker's pain level is rated a 4 out of 10 to the left wrist, a 6 to 7 out of 10 to the lumbar spine and the left knee, a 7 out of 10 to the left hip, and a 5 to 6 out of 10 to the right foot. The treating physician noted prior post-operative physical therapy of an unknown quantity and also noted that the injured worker has had no change in function. The treating physician requested physical therapy three times four to the left knee, but the documentation provided did not indicate the specific reason for the requested therapy to the left knee. However the treating physician did request for the injured worker to continue with physical therapy to the right foot.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 3x4 left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Submitted reports have no acute flare-up or specific physical limitations to support for physical/occupational therapy. 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. There is 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. It is unclear how many PT/OT sessions the patient has received or what functional outcome was benefited if any. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It appears the patient has received prior sessions of PT/OT without clear specific functional improvement in ADLs, functional status, or decrease in medication and utilization without change in neurological compromise or red-flag findings to support further treatment. The Physical Therapy 3x4 left knee is not medically necessary or appropriate.