

Case Number:	CM15-0124208		
Date Assigned:	07/08/2015	Date of Injury:	01/23/2008
Decision Date:	08/05/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	06/29/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 67 year old female, who sustained an industrial injury on 01/23/2008. The injured worker reported slipping and falling landing on her knees to the floor with her neck, back, and right hip hitting the wall. The injured worker was diagnosed as having musculoligamentous of the lumbar spine sprain/strain, multi-level lumbar spondylosis, status post right total knee arthroplasty, and status post left total knee arthroplasty. Treatment and diagnostic studies to date has included medication regimen, above noted procedures, physical therapy with an unknown quantity, and home exercise program. In a progress note dated 06/03/2015 the treating physician reports intermittent swelling of the right knee, medial joint pain to the left knee, instability and weakness when the injured worker ambulates on uneven surfaces, intermittent, aching, sharp, stabbing pain with mild to moderate intensity to the back, and with weakness to the legs. Examination reveals mild tenderness to the medial joint line and the medial aspect of the left knee, mild fullness to the anterior region of the right knee, tenderness to the lumbar paraspinal muscles, and decreased range of motion to the lumbar spine. The injured worker's pain is rated a 3 out of 10 with rest and a 5 out of 10 with activity. The documentation provided noted prior physical therapy but the documentation did not indicate the quantity of physical therapy sessions performed. The documentation provided also did not indicate if the injured worker experienced any functional improvement with prior physical therapy sessions. The treating physician requested physical therapy two times a week for four weeks to the lumbar spine, but the documentation did not indicate the specific reason for the requested therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 4 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant sustained a work injury in January 2008 and underwent bilateral total knee replacements in November 2013 in July 2014. She had postoperative physical therapy including instruction in a home exercise program. When seen, she was having low back and bilateral knee pain. Pain was rated at 3-5/10. She was having lower extremity weakness. Physical examination findings included a BMI of nearly 34. There was decreased lumbar spine range of motion with decreased hip flexion strength. There was a normal gait without use of an assistive device. There was decreased knee range of motion with mild tenderness. Authorization for eight sessions of physical therapy for the lumbar spine was requested. The claimant is being treated for chronic pain with no new injury to the lumbar spine. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to reestablish or revise the claimant's home exercise program. The request is not medically necessary.