

<b>Case Number:</b>	CM15-0170955		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	08/30/2011
<b>Decision Date:</b>	10/15/2015	<b>UR Denial Date:</b>	08/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/31/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 55 year old male who sustained an industrial injury on 8-30-11. Diagnoses are lumbago, sprain-strain lumbar region, osteoarthritis unspecified lower leg, and morbid obesity. Previous treatment includes medications, physical therapy-left knee, MRI-lumbar spine 2-17-15, X-ray left knee 12-9-11 and 7-30-15, electromyography-nerve conduction studies of lower extremities 2-17-15: evidence of an acute right L5 and S1 lumbosacral radiculopathy, crutches, and left knee arthroscopy-2011. In a progress report dated 7-30-15, the treating physician notes the injured worker states "he feels his left popped out of place about 2 weeks ago." He reports constant pain and that he is doing therapy with no results. He has completed 6 sessions of therapy. Medication is Voltaren. Left knee surgery was done 10-18-11. There is no locking or giving way of the left knee but there is a sensation of it being wobbly. It is noted that the injured worker reports the onset of low back pain has been present for a couple of years and that he has not had any treatment for it and notes that he gets Norco from his primary care physician and uses over the counter creams. Standing bilateral knees series xrays done 7-30-15 show medial joint space narrowing bilaterally. Left knee exam shows posteromedial joint line tenderness, increased with McMurray's and Apley's grind test, and slightly with bounce home. Standing lumbosacral spine series shows minimal degenerative changes. Tenderness to palpation is noted along the lower spinous processes and right paravertebral muscles. The assessment is lumbosacral spine pain, strain, superimposed upon degenerative disc disease per MRI 2-17-15, left knee status post arthroscopy with partial medial and lateral menisectomies 10-18-11, and morbid obesity. Weight loss was discussed. The injured worker has started swimming 3 days a week. He will continue his course of active physical therapy to learn exercises and will continue independently thereafter. Work status is to return to full duty on 7-30-15. A request for

authorization is dated 8-6-15. The requested treatment of physical therapy 3 times a week for 4 weeks to the left knee and physical therapy 3 times a week for 4 weeks for the lumbar spine was not certified on 8-10-15.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Physical therapy 3 times a week for 4 weeks for the left knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): General Approach, Initial Assessment, Medical History, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Activity Alteration, Work Activities, Follow-up Visits. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for Physical therapy 3 times a week for 4 weeks for the left knee, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy 3 times a week for 4 weeks for the left knee is not medically necessary.

#### **Physical therapy 3 times a week for 4 weeks to the lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): General Approach, Initial Assessment, Medical, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Physical Methods, Activity, Work, Follow-up Visits, Special Studies, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for Physical therapy 3 times a week for 4 weeks to the lumbar spine, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment

process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits.

Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the current request for Physical therapy 3 times a week for 4 weeks to the lumbar spine is not medically necessary.