

<b>Case Number:</b>	CM15-0093341		
<b>Date Assigned:</b>	05/19/2015	<b>Date of Injury:</b>	06/04/2013
<b>Decision Date:</b>	06/19/2015	<b>UR Denial Date:</b>	04/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 26-year-old female patient who sustained an industrial injury on 06/04/2013. The initial report of illness dated 06/05/2013 reported the patient having slipped landing on the top of her wrist and right middle finger with resulting pain and injury. She has subjective acute symptom of right hand pain. Objective findings showed the right third digit exquisite tenderness to palpation over the dorsal aspect, and with 2-3 plus edema noted and motor/sensory intact. She was diagnosed with finger fracture, knee contusion, and knee strain/sprain and knee pain. Radiography study performed showed evidence of a non-displaced fracture of the right 3rd digit, middle phan. The finger was splinted; she declined a Toradol injection, and was given a referral. The patient was to return to a modified work duty. Another follow up visit on 07/12/2013 reported subjective complaint of low back pain, left lower extremity knee and hip pain. The following diagnoses were applied: lumbar spine strain/sprain; lumbar spine radiculitis; left knee strain/sprain; left hip strain. The plan of care noted the patient requiring a knee brace, chiropractic manual sessions, referral, and radiography scan of lumbar spine and left hip.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy 8 sessions low back and knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2): 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The patient has already completed a course of physical therapy. The request is in excess of these recommendations per the California MTUS. There is no explanation why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions. Therefore, the request is not medically necessary.