

<b>Case Number:</b>	CM15-0099549		
<b>Date Assigned:</b>	06/02/2015	<b>Date of Injury:</b>	08/10/2011
<b>Decision Date:</b>	07/03/2015	<b>UR Denial Date:</b>	04/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2015

### 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: Texas, California  
 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 69-year-old female, who sustained an industrial injury on 8/10/11. She reported initial complaints of falling down stairs: cervical spine, lumbar spine, right shoulder and left foot injury. The injured worker was diagnosed as having chronic neck pain; chronic low back pain; chronic left shoulder pain; chronic left foot pain-atypical reflex sympathetic dystrophy. Treatment to date has included status post lumbar sympathetic nerve blocks L2-3/L3-4 x3; physical therapy; medications. Diagnostics CT scan cervical and lumbar spine (2011); X-ray cervical, lumbar spine; left shoulder, left tibia; bilateral feet (4/16/15). Currently, the PR-2 notes dated 4/16/15 indicated the injured worker was referred to this office for complaints of cervical spine, right shoulder, lumbar spine and left foot pain. She complains of constant sharp and dull aching pain in her neck, right and left shoulders, low back, left foot and left ankle. The pain radiates into the left leg. The low back pain is equal to the leg pain. The neck pain does radiate to the left arm. The neck pain is equal to arm pain. She rates her pain as 8 on a scale of 1-10 with 10 as worst. There is associated numbness, tingling and weakness. The pain is aggravated by sitting, standing, walking and alleviated by medications. The activities of daily living that are painful or difficult for this injured worker are described as sitting. Current medications are documented as: Amitriptyline, Atenolol, Clopidogrel, Estradiol, Gabapentin, Losartan HCT, Nucynta ER and Simvastatin. On physical examination the provider documents the injured worker's gait is left antalgic with foot somewhat inverted during stance phase. There is tenderness to palpation to the cervical paraspinal muscles, trapezius and rhomboids. There is tenderness to palpation to the lumbar paraspinals more so on the left with no increased pain with percussion of the spine. The cervical and lumbar ranges of motion are both 70% of normal. Spurling's maneuver is negative and straight leg raising is negative. Motor function testing was performed and 5/5 full function. The left arm deltoid is 5, biceps 5, wrist extensors 5, triceps 5, wrist flexors 5, finger flexors 5, intrinsic 5 (requires encouragement and there is diffuse and

weakness in the left arm. The left foot requires encouragement and there is diffuse giveaway weakness in the left foot. She has no sensory hypothesis and reflexes are notes as trace in both upper and lower extremities. There is negative clonus and Hoffman's sign. Shoulders noted as full passive range of motion with the left shoulder with discomfort/pain with elevation above 90 degrees. It was difficult to assess impingement signs due to pain. The left foot demonstrates diffuse hypesthesia with allodynia extending into the mid-calf. The foot is held somewhat inverted low passive correction to neutral is obtainable and there is no discoloration noted. Sensation is equal in both feet. She has had CT scans of the cervical and lumbar spine in 2011, which demonstrate degenerative changes with no significant spinal stenosis at that time. She has also has x-rays most recently (4/16/15) of the cervical and lumbar spine which also reveal degenerative changes. The left shoulder x-ray on this date notes no significant abnormalities with slight AC joint arthritic changes. The left foot x-rays on this date note a slight disuse osteopenia. She continues to receive active treatment for her left lower extremity which has been judged to be atypical reflex sympathetic dystrophy. Sympathetic blocks have not been helpful. The most recent discussion was regarding a possible spinal cord stimulator but the injured worker is reluctant at this time. The provider's treatment plan includes a request for additional physical therapy for the left leg and foot desensitization. His request that was denied by Utilization Review is Physical therapy 3 times a week for 4 weeks for the left foot. The patient was authorized for 12 PT visits and had completed 18 visits till date for this injury.

### **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 foot:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy, page 9.

**Decision rationale:** Physical Therapy 3 times a week for 4 weeks for the left foot. The guidelines cited below state, "allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." The patient was authorized for 12 PT visits and had completed 18 visits till date for this injury. Previous conservative therapy notes were not specified in the records provided. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Previous PT visits notes were not specified in the records provided. Per the guidelines cited, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of the request for Physical Therapy 3 times a week for 4 weeks for the left foot is not fully established for this patient.