

Case Number:	CM13-0063834		
Date Assigned:	12/30/2013	Date of Injury:	01/12/2007
Decision Date:	05/12/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/10/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54-year-old male who reported an injury on 01/12/2007. The mechanism of injury was not provided in the medical records. The injured worker reported pain to the right knee. The injured worker had positive quad atrophy. The injured worker had mild to moderate pain at the anteromedial and anterolateral fat pad with mild effusion noted. The injured worker continued to have grinding and catching sensation in the anteromedial and anterolateral fat pad region, as well as mild discomfort at the distal tibial tubercle region. The injured worker was able to bend his knee to 130 degrees actively and passively. The injured worker was diagnosed with pain in the joint, lower leg. Past medical treatment included medications and physical therapy. Diagnostic studies include a CT of the right knee without contrast on 05/23/2013, and X-rays of the right knee on 05/20/2013, 06/10/2013, and 07/17/2013. An MRI of the right knee without contrast was done on 10/16/2013. The request for authorization was not provided in the medical records; therefore, the clinical note from the date the treatment was requested is unclear.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY FOR THE RIGHT KNEE, THREE (3) TIMES PER WEEK FOR SIX (6) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 98-99. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE, PAGE 98-99

Decision rationale: According to the California MTUS Guidelines, physical therapy allows for a fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine in the condition of myalgia and myositis, unspecified at 9 to 10 visits and neuralgia, neuritis, and radiculitis, unspecified at 8 to 10 visits. The documentation submitted for review indicated the injured worker has completed at least 25 physical therapy sessions to date with functional gains. As the injured worker has exceeded the recommended number of physical therapy sessions, and the request as submitted for an additional 18 physical therapy sessions would exceed the guideline recommendations; exceptional factors were not present to warrant further physical therapy. Given the above, the request for physical therapy for the right knee, three times per week for six weeks is non-certified.