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| Case Number: | CM14-0003605 | | |
| Date Assigned: | 01/31/2014 | Date of Injury: | 04/06/2011 |
| Decision Date: | 06/20/2014 | UR Denial Date: | 12/27/2013 |
| Priority: | Standard | Application Received: | 01/09/2014 |

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 & Rehabilitation and is licensed to practice in Illinois. 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 25 year old female who reported an injury on 04/06/2011, due to twisting injury to the left knee. The clinical note dated 07/10/2013 presented left knee pain and tightness with grinding and catching in the retropatellar space. The injured worker's physical exam noted a severe contracture of the knee of approximately 15 degrees, she was unable to fully straighten the knee, there was a mild-articular effusion upon inspection, and moderate patellar crepitus present. The range of motion of the left knee was extension at -15 degrees, and flexion at 125 degrees. The injured worker is diagnosed with osteochondral defect of the knee. The provider recommended physical therapy 3 times a week for 4 weeks on the left knee. The request for authorization form is dated 07/24/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS ON THE LEFT KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: POST SURGICAL TREATMENT GUIDELINES, KNEE, 24

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

Decision rationale: The California MTUS state that 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. There was a lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy of the prior therapy. In addition, the request for 12 visits exceeds guideline recommendations for 10 sessions. Therefore, the request is not medically necessary.