

<b>Case Number:</b>	CM14-0007746		
<b>Date Assigned:</b>	02/10/2014	<b>Date of Injury:</b>	06/13/2013
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	12/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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 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 51 year old female whose date of injury is 06/13/2013. A coworker forced a door open which hit directly on the injured worker's left knee. Left knee MRI dated 09/23/13 revealed mild soft tissue edema, mild patellofemoral compartment arthrosis, mild patellar tendinosis, and no meniscal tear. She underwent left knee injection on 10/01/13 and has completed 9 physical therapy visits. Physical medicine consultation dated 11/21/13 indicates that chief complaint is knee pain. Previous physical therapy has been 20-40% helpful and effective. Diagnoses are left knee pain, chronic; underlying chondromalacia patella; and mechanical instability and gait instability. Progress report dated 12/04/13 indicates that she has ongoing problems with persistent pain in the left knee. Visit note dated 02/06/14 indicates that pain is rated as 7/10. Current medication is Pantoprazole.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PT: TEN ADDITIONAL SESSIONS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 114, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Physical Medicine Treatment.

**Decision rationale:** The Official Disability Guidelines support up to 9 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The injured worker has completed 9 physical therapy visits to date. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. Based on the clinical information provided, the request for 10 additional sessions of physical therapy is not recommended as medically necessary.

**FUNCTIONAL RESTORATION PROGRAM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs: Multi-disciplinary Pain Management Programs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section on Chronic Pain Programs (Functional Restoration Programs) Page(s): 30-32.

**Decision rationale:** The submitted records fail to establish that the injured worker has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. There is no indication that the injured worker has undergone a pre-program mental health evaluation and/or functional capacity evaluation as required by CA MTUS guidelines to assess patient appropriateness for the program and to establish baseline levels of functioning. Based on the clinical information provided, the request for functional restoration program is not recommended as medically necessary.