

<b>Case Number:</b>	CM14-0017761		
<b>Date Assigned:</b>	04/16/2014	<b>Date of Injury:</b>	02/03/2004
<b>Decision Date:</b>	06/03/2014	<b>UR Denial Date:</b>	01/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2014

### 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 Pain Medicine and is licensed to practice in Texas and Ohio. 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 71 year old female who reported an injury on 02/03/2004 secondary to a slip and fall. The diagnosis is osteoarthritis and quadriceps weakness of the right knee status post total knee replacement in 2006. The injured worker was evaluated on 01/15/2014 for reports of increased stiffness and swelling and difficulty standing from seated position. The injured worker was also evaluated on 03/26/2014 for persistent right knee pain. The treatment plan indicated medication and physical therapy. Request for authorization of physical therapy on 11/13/2013 for status post right knee replacement with stiffness and swelling and difficult standing from seated position. The patient was evaluated on 11/07/2013 and noted to have non antalgic and 125 degrees of flexion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY 2 X WEEK FOR 6 WEEKS:** Upheld

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

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

**Decision rationale:** The request for physical therapy two (2) times a week for six (6) weeks is non-certified. The California MTUS guidelines for physical medicine state active therapy is beneficial in restoring flexibility, strength, function, range of motion, and to alleviate discomfort over a total of 9-10 visits. The injured worker was noted to have previously received 36 visits of physical therapy; however, the documentation failed to show evidence of objective functional gains made with prior treatment. Therefore, the request for 12 more visits exceeds these guidelines. There is also a lack of documentation of the efficacy of these treatments. Therefore, the request for additional physical therapy is not medically necessary.