

Case Number:	CM14-0113601		
Date Assigned:	08/01/2014	Date of Injury:	12/13/2010
Decision Date:	09/10/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/21/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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 who had a work-related injury on 12/13/10. The mechanism of injury is described as twisting the left knee. Subsequently, the left knee swelled. Two left knee surgeries in 2011 and 2013 are noted. Oral medications included Celebrex, Norco, Ambien, Percocet, Cymbalta, Ibuprofen, and Vicodin. Four injections in the left knee are noted. The note of 04/09/14 stated that the injured worker completed physical therapy and noted benefit. Progress report dated 06/12/14 indicates that the injured worker has complaints of aching, soreness, tenderness and throbbing in the left knee. Symptoms worsen when bending, climbing up and down inclined surfaces including stairs or hills, lifting, and walking. Pain is rated 7-10/10. Difficulty in sleeping and standing is also noted. The injured worker experiences dizziness, nausea, and leg pain. Physical examination, active and passive patellar grind test and patellar apprehension test are abnormal. McMurray's test is positive for medial joint line pain. X-ray dated 05/2012 showed mild tricompartmental degenerative changes with small effusion. Imaging on 11/12/12 indicates tricompartment osteoarthritis and subpatellar chondromalacia. The injured worker is walking with a cane. Plan of care includes, continuing a home exercise program, medications, and physical therapy. Prior utilization review on 06/20/14 was partially certified. The injured worker was at risk for falls, subsequently two sessions of physical therapy for evaluation and gait training were certified. There has been no documentation of significant objective deficits and a specific plan of care with reasonable goals submitted since then.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy two (2) times a week for five (5) weeks for the Left Knee: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter, Physical medicine treatment.

Decision rationale: The request for Physical Therapy two (2) times a week for five (5) weeks for the Left Knee is not medically necessary. The clinical documentation submitted for review does not support the request for additional physical therapy. The note of 04/09/14 stated that the injured worker completed physical therapy and noted benefit. There has been no documentation of significant objective deficits and a specific plan of care with reasonable goals submitted since the prior utilization review on 06/20/14 which was partially necessary. As such, medical necessity has not been established.