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| Case Number: | CM15-0019269 | | |
| Date Assigned: | 02/09/2015 | Date of Injury: | 06/07/1990 |
| Decision Date: | 05/01/2015 | UR Denial Date: | 01/20/2015 |
| Priority: | Standard | Application Received: | 02/02/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 63-year-old male who reported an injury on 06/07/1990. He was diagnosed with left knee pain. His past treatments were noted to include medications, surgery and physical therapy. The surgical history was noted to include total knee arthroplasties bilaterally on 10/10/2014. On 12/29/2014, the injured worker reported knee pain rated 7/10. It was noted that symptoms have been present since the date of injury. Upon physical examination of the left knee, he was noted to have moderate to severe decreased range of motion of the left knee. His current medications were not provided. The treatment plan was noted to include authorization for physical therapy and a follow-up appointment on 02/06/2015. A request was submitted for Physical therapy once a week for eight weeks for the left knee; however, the rationale was not provided. The Request for Authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy once a week for eight weeks for the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: The request for physical therapy once a week for 8 weeks for the left knee is not medically necessary. The California MTUS Guidelines recommend active therapy for restoring flexibility, strength, endurance, function, range of motion and can alleviate discomfort. The guidelines recommend 24 visits of post-op therapy for a knee arthroplasty. The clinical documentation submitted for review indicated that the patient has had physical therapy; however, it is unclear the amount of completed physical therapy and whether the injured worker had significant objective functional improvement with the previous physical therapy provided. There were no exceptional factors to warrant additional visits beyond the guideline recommendations. In the absence of this documentation, the request is not supported by the guidelines. As such, the request is not medically necessary.