MAXIMUS Federal Services

Case Number:	CM15-0207666		
Date Assigned:	10/26/2015	Date of Injury:	09/18/2014
Decision Date:	12/07/2015	UR Denial Date:	10/08/2015
Priority:	Standard	Application Received:	10/21/2015

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 57 year old female, who sustained an industrial-work injury on 9-18-14. She reported initial complaints of right knee and low back pain. The injured worker was diagnosed as having persistent quad and VMO (vastus medialis obliquus) atrophy and persistent right knee pain after a capsular injury, right knee joint. Treatment to date has included medication and unspecified amount of sessions of physical therapy (minimal improvement), steroid injection (70-80% improvement). Currently, the injured worker complains of knee pain causing difficulty with walking. The injured worker is not working. Per the primary physician's progress report (PR-2) on 9-4-15, exam notes no evidence of effusion, full range of motion, no pain in the medial and lateral facet and no pain in the medial or lateral joint line, no varus-valgus laxity at 0 degrees or 30 degrees of knee flexion, negative dial test at 30 degrees and 90 degrees, negative McMurray, quad and VMO atrophy is significant with 2 cm of side to side distance persistent from last time. Current plan of care includes physical therapy. The Request for Authorization requested service to include Physical therapy 2-3 x 6 right knee. The Utilization Review on 10-8-15 denied the request for Physical therapy 2-3 x 6 right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2-3x6 right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of deficits to support for further treatment beyond the sessions already rendered. Review of submitted reports noted the patient has clinical findings of normal range, good strength with normal sensation and reflexes. Clinical reports submitted also had no focal neurological deficits or ADL limitation to support for further therapy treatment. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals when the patient has no defined deficits. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated necessity or indication to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that should have been transitioned to an independent home exercise program. Submitted reports have not adequately demonstrated the indication to support for the physical therapy. The Physical therapy 2-3x6 right knee is not medically necessary and appropriate.