

Case Number:	CM15-0209653		
Date Assigned:	10/28/2015	Date of Injury:	06/21/2014
Decision Date:	12/11/2015	UR Denial Date:	10/14/2015
Priority:	Standard	Application Received:	10/25/2015

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 50-year-old female with a date of industrial injury 6-21-2014. The medical records indicated the injured worker (IW) was treated for right knee contusion and sprain. In the 9-10-15 and 10-1-15 progress notes, the IW reported persistent right knee pain with prolonged walking, standing and climbing. She was taking Ibuprofen without side effects. On examination (10-1-15 notes), her gait was normal. There was tenderness to palpation of the anterior knee. Range of motion was 0 to 120 degrees. No swelling, effusion, instability or crepitation was present. McMurray's test was negative. Treatments included physical therapy (at least 4 sessions), aquatic therapy (at least 12 sessions) and acupuncture (at least 6 sessions) with partial improvement; and home exercise. The provider stated the MRI of the right knee on 9-25-15 showed no ligament or meniscal tears and no fractures; findings were consistent with contusion or mild strain. The IW was on modified work duty. There was no documentation of functional gains from previous therapy and no rationale given for exceeding the recommended number of physical therapy sessions. A Request for Authorization was received for physical therapy three times a week for three weeks for the right knee. The Utilization Review on 10-14-15 non-certified the request for physical therapy three times a week for three weeks for the right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times a week for 3 weeks to the 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: This claimant was injured in 2014 with a right knee contusion and sprain. There have been about 16 total therapy situations. The patient is on modified duty. The objective functional benefit out of past therapy is not noted. The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. This request for more skilled, monitored therapy is not medically necessary.