

<b>Case Number:</b>	CM15-0023583		
<b>Date Assigned:</b>	02/13/2015	<b>Date of Injury:</b>	09/20/2012
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/09/2015

### 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: 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:

The injured worker is a 42 year old male, who sustained a work/ industrial injury on 9/20/12 from a slip and fall. He has reported symptoms of right knee pain. Prior medical history was negative. Surgery included anterior cruciate ligament repair of the right knee on 6/25/13 along with a right knee arthroscopy with lysis of adhesions on 10/7/14. The diagnosis have included sprain of cruciate ligament of the right knee. Treatments to date included physical therapy and medication. Diagnostic studies were not available for review. Medications were not listed. On 1/19/15, the IW had range of motion of 0 degrees extension and 120 degrees flexion to the right knee. There was on effusion or tenderness about the medial joint line. There was a negative patellar grind, Lachman's test, and anterior drawer test. There was no tenderness about the medial/lateral femoral condyle. Quadriceps strength and hip flexor strength was 5/5. A request was made for additional physical therapy sessions. On 1/27/15, Utilization Review non-certified a 12 physical therapy sessions, 3x/wk for 4 weeks for the right knee, noting the Medical treatment Utilization Schedule (MTUS) Guidelines, Post Surgical Rehabilitation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 physical therapy sessions, 3x/wk for 4 weeks for the right knee:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Pages 58-60.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Continued physical therapy is predicated upon demonstration of a functional improvement. The medical record showed that the patient did have evidence of functional improvement. I am reversing the previous utilization review decision. 12 additional visits of physical therapy is medically necessary.