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| Case Number: | CM15-0056152 | | |
| Date Assigned: | 04/16/2015 | Date of Injury: | 07/08/2013 |
| Decision Date: | 05/15/2015 | UR Denial Date: | 03/19/2015 |
| Priority: | Standard | Application Received: | 03/24/2015 |

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, Pain Management

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 50 year old female patient who sustained an industrial injury on 07/08/2013. A primary treating office visit dated 02/16/2015 reported present complaints of neck pain and stiffness that radiates into the upper back and bilateral shoulder blades. She has bilateral shoulder pain with associated numbness and tingling. She is with low back pain accompanied with parasthesias down the right leg. She has frequent knee pain, right and left knee pains secondary to compensating for the right. The following diagnoses are applied: cervical spine strain/sprain, myofasciitis, intermittent radiculopathy bilateral shoulders; lumbar spine strain/sprain, myofasciitis, intermittent lower extremity radiculopathy, and status post arthroscopic surgery right knee with residual pain and swelling. She is temporarily totally disabled. The plan of care involved prescribing Anaprox, Prilosec, and Flexeril. Recommending physical therapy, radiography and magnetic resonance imaging. A primary treating office visit dated 03/05/2014 reported subjective complaint of right knee with sharp pain over the surgical site and restricted range of motion. The diagnostic impression noted status post right knee arthroscopy and partial medial meniscectomy 01/20/2014. She will remain temporary totally disabled and return for follow up in two weeks. The plan of care involved continue Enovax, Ibuprofen, and Norco. A progress report dated February 16, 2015 indicates that the patient received 12-14 sessions of postoperative physical therapy. Physical examination of the right knee shows swelling and tenderness with capitation upon range of motion. The patient also has limited range of motion in the right knee. She is not able to kneel or squat. The treatment plan recommends physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy two times a week times six weeks for the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. Official Disability Guidelines has more specific criteria for the ongoing use of physical therapy. Official Disability Guidelines recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior physical therapy sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, when added to the previous number of therapy sessions, the request exceeds the amount of physical therapy recommended by Official Disability Guidelines and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.