

<b>Case Number:</b>	CM15-0241272		
<b>Date Assigned:</b>	12/18/2015	<b>Date of Injury:</b>	01/30/2009
<b>Decision Date:</b>	01/22/2016	<b>UR Denial Date:</b>	11/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2015

### 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:

The injured worker is a 69 year old female, who sustained an industrial injury on 1-30-09. The injured worker was diagnosed as having presence of left artificial knee joint, joint disorder of left knee, myalgia, and abnormalities of gait and mobility. Treatment to date has included a left total knee replacement on 8-6-15, at least 12 physical therapy visits, and a home exercise program. The most recent physical therapy progress report was dated 11-10-15. Physical exam findings on 11-10-15 included left knee tenderness to palpation. Left knee motor strength was noted to be 5 of 5 in flexion and extension. On 11-10-15, the injured worker complained of left knee pain rated as 3 of 10. On 11-19-15, the treating physician requested authorization for physical therapy for the left knee 2x6. On 11-25-15 the request was non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for left knee, 2x a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Knee.

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

**Decision rationale:** Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20-9792.26 MTUS (Effective July 18, 2009) Page 98 of 127. This claimant was injured in 2009 with a left artificial knee joint but continued pain and abnormalities of gait and mobility. There was a left knee total replacement in August, and at least 12 sessions of PT. There is pain, but no physical deficits documented. For example, there is 5 out of 5 motor strength in both flexion and extension. 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. In addition, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. In this case, the motor strength shows no deficits; it is not clear what deficits would be functionally addressed through the physical therapy, so the true clinical need for it is not established. In addition, 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. The request is not medically necessary.