

Case Number:	CM14-0121633		
Date Assigned:	09/25/2014	Date of Injury:	01/12/2014
Decision Date:	10/28/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	08/01/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 30-year old deputy sheriff tripped and fell while pursuing a subject on 11/12/14, fracturing his left fifth metatarsal. He also reported a left knee injury from the same incident. An internal fixation of the metatarsal fracture was performed on 2/3/14. He was referred to an orthopedist for his knee symptoms. Most of the records available for review concern a previous shoulder injury. There is a single report from the primary physician dated 1/29/14 with a conclusion that the patient is likely to have a medial meniscal tear and a plan to have an magnetic resonance imaging (MRI) performed. All additional information in this summary was obtained from the utilization review report dated 7/9/14. The primary physician's 3/31/14 progress report noted that the MRI showed bone edema of the medial femoral condyle. Physical therapy (PT) was recommended. A 5/12/14 note documented minimal improvement with PT. Exam showed full range of motion of the knee, and tenderness over the medial femoral condyle and the saphenous nerve. The diagnoses were revised to bone contusion and saphenous neuritis. Patient was to use a topical NSAID with a neuropathic agent and Lidocaine, and to continue PT. By 6/25/14 the patient had developed sharp pain over the patellar tendon. His exam was unchanged. Diagnosis was changed to patellar tendonitis. Additional PT was recommended, as was Voltaren gel. His work status was temporary total disability (TTD). A 6/24/14 PT report showed good strength and range of motion of the knee, but "severe impairment with squatting and moderate issues with sitting". Per the UR report, the patient has had extensive therapy for his knee, beginning in March 2014, with a recent authorization of an additional 12 visits, of which only four had been completed.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Physical therapy sessions for the left knee, 2 times per week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-Physical Medicine Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-338, Chronic Pain Treatment Guidelines Introduction, Functional Improvement Page(s): 9. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines, Knee

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, all therapies should be focused on the goal of functional restoration rather than merely the elimination of pain, and assessment of treatment efficacy is accomplished by reporting functional improvement. Per the first guideline cited above "chronic pain" means any pain that persists beyond the anticipated time of healing. According to the ACOEM Practice Guidelines, for cases that do not involve significant injury, the patient can be advised to do early straight-leg-raising and active range-of-motion exercises, especially bicycling, with emphasis on closed-chain exercises such as squats. A few visits to a physical therapist can serve to educate the patient about an effective exercise program. The ODG do not recommend over 9 visits in 8 weeks for non-surgical diagnoses such as sprains and strains, for tibialis tendonitis, or arthritis of the knee. The clinical findings in this case do not support the continuation of physical therapy for this patient. He apparently has undergone multiple PT sessions without significant functional recovery, despite demonstration of normal strength and range of motion. He had a recent authorization of 12 additional visits of PT, which is more than the total number of visits likely to be useful for non-surgical knee conditions. He should have transitioned to a home exercise program well before now. There is no documentation of specific functional goals that are likely to be achievable with formal physical therapy and not with home exercise. Based on the evidence-based guidelines cited above and the clinical findings in this case, 12 physical therapy sessions for the left knee, 2 times per week for 6 weeks, are not medically necessary. They are not medically necessary because the patient has not demonstrated functional improvement with the extensive therapy he has already received, because he has already exceeded the number of PT sessions likely to be helpful for his diagnoses and should have transitioned to home exercises, and because no specific functional goals have been identified that could be accomplished with physical therapy but not home exercises. Therefore the request is not medically necessary.