

Case Number:	CM15-0114110		
Date Assigned:	06/22/2015	Date of Injury:	01/15/2014
Decision Date:	07/21/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/15/2015

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

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 45 year old female, who sustained an industrial injury on 1/15/14. She reported she twisted her right knee. The injured worker was diagnosed as having left hip and groin pain, compensatory overuse of left knee pain and status post right knee chondroplasty lateral retinacular release and lateral medial meniscectomy on 8/21/14. Treatment to date has included right knee injections, right knee, physical therapy, acupuncture, and medication including Norco and Celebrex. Currently, the injured worker continues with complaints of left hip pain and bilateral knee pain. The treating physician requested authorization for physical therapy for the left knee as an outpatient 3x4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the left knee as an outpatient, thrice weekly for four weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. There are unchanged chronic symptom complaints and clinical findings without clear neurological deficits. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. The patient is without clear specific functional improvement in ADLs, work status, or decrease in medication and utilization without physiologic evidence of tissue insult, neurological compromise, or red-flag findings to support further treatment. The Physical therapy for the left knee as an outpatient, thrice weekly for four weeks is not medically necessary and appropriate.