

Case Number:	CM15-0170561		
Date Assigned:	09/11/2015	Date of Injury:	05/20/2009
Decision Date:	10/08/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	08/31/2015

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 57-year-old male who sustained an industrial injury on 05-20-2009. Current diagnoses include status post left knee total knee arthroplasty, left knee degenerative joint disease, and knee degenerative osteoarthritis. Report dated 07-22-2015 noted that the injured worker presented for postoperative visit for the left knee. Currently ambulating with no assistive devices. The injured worker stated that pain has been aggravated in the past week, but feels it may be due to the weather. Currently the pain is radiating down the leg. Physical examination of the left knee revealed a well-healed incision; range of motion is 5-120, mild calf tenderness, and 1+ effusion. Previous treatments included medications, left total knee arthroplasty on 04-10-2015, and physical therapy. The treatment plan included continuing physical therapy, aspirated 15cc of blood from left knee, and follow up in 6 weeks. It was noted that the injured worker had completed approximately 20 sessions of physical therapy. The only physical therapy progress report included was dated 04-30-2015. The utilization review dated 08-10-2015, non-certified the request for post-operative physical therapy 3 times a week for 4 weeks for the left knee due to already being approved for 32 visits but has only completed 21 visits so far and modified the request for physical therapy 3 times a week for 4 weeks for the right knee to physical therapy 3 x 2 for the right knee based on the ongoing symptoms and concurrent physical therapy for the right is reasonable.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative physical therapy 3 times a week for 4 weeks for the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, and Postsurgical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Guidelines.

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

Decision rationale: The Chronic Pain Guidelines, post-operative therapy allow for 24 visits over 10 weeks for arthroplasty over a postsurgical physical medicine treatment period of 4 months. Submitted reports have not adequately demonstrated the indication to support further physical therapy beyond the guidelines criteria. The patient's TKA is now over 5 months without documented functional limitations or complications to allow for additional physical therapy. The patient is without significant functional improvement from treatment of 32 visits approved with 21 visits already rendered to support for an additional 12 PT visits for a total of 44 sessions. The Post-operative physical therapy 3 times a week for 4 weeks for the left knee is not medically necessary and appropriate.

Physical therapy 3 times a week for 4 weeks for the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, and Postsurgical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Guidelines.

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

Decision rationale: Review indicates the request for PT for the right knee was modified for 6 visits with ongoing symptoms. 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. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. 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 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic 2009 injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy 3 times a week for 4 weeks for the right knee is not medically necessary and appropriate.