

<b>Case Number:</b>	CM15-0093628		
<b>Date Assigned:</b>	05/19/2015	<b>Date of Injury:</b>	05/06/2013
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2015

### 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, Hawaii

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 64 year old female, who sustained an industrial injury on May 6, 2013. She reported a left knee and low back injury. The injured worker was diagnosed as having left knee tendinitis/bursitis, patellofemoral misalignment, and status post left knee arthroscopic surgery in 2013. Diagnostic studies to date have included x-rays and MRI. Treatment to date has included a single-point cane and medications including pain, non-steroidal anti-inflammatory, and Chondroitin-Glucosamine. On February 19, 2015, the injured worker reports continued with left knee symptoms despite undergoing arthroscopic surgery in 2013. The physical exam revealed a left antalgic gait, well-healed arthroscopic portal knee incisions, neutral alignment of the knee, medial joint line pain with palpation, medial tracking of the patella within the trochlear notch, an elevated quadriceps angle, full knee range of motion, intact sensation, and normal bilateral motor strength, deep tendon reflexes, and circulation. The treatment plan includes an increase in pain medication and the addition of a non-steroidal anti-inflammatory medication. The requested treatment is physical therapy for the left knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient Physical Therapy Evaluation & treatment three times a week for four weeks (3x4) for the left knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The patient presents with chronic left knee pain. The current request is for physical therapy (PT) evaluation and treatment 3 x 4 for the left knee. UR notes that this patient has undergone 12 physical therapy sessions to the left knee previously and was provided 33 postop physical therapy sessions following left knee arthroscopy on 7/25/13. Neither the RFA nor physicians report requesting this service were provided for review. MTUS guidelines indicate that Physical Therapy is recommended: Physical Medicine guidelines state "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. For myalgia and neuritis type conditions, MTUS Guidelines recommend 8-10 sessions of physical therapy. The clinical records reviewed do not provided any compelling reason to perform additional PT. There was no documentation provided that indicated prior treatment produced objective functional improvements. There is no information in the reports presented to indicate that the patient has suffered a new injury and no new diagnosis is given to substantiate a need for additional physical therapy beyond the MTUS guideline recommendation. The current request is not medically necessary and the recommendation is for denial.