

Case Number:	CM13-0043452		
Date Assigned:	12/27/2013	Date of Injury:	04/07/2007
Decision Date:	02/25/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	10/24/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice and is licensed to practice in Texas. 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 physician 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:

The patient is a 52-year-old female who reported a work-related injury on 04/07/2007 as result of a fall. The patient subsequently presents for treatment of the following diagnoses: right rotator cuff tear with retraction, wrist sprain and hand sprain to the right, internal derangement of the right knee, ankle sprain with instability, memory loss and sexual dysfunction. The clinical note dated 10/09/2013 reports the patient was seen under the care of [REDACTED] for her persistent right knee and foot pain. The provider documents the patient reports she has a hinged brace which is not working well and requires replacement. The provider documents the patient has never utilized an unloading brace. The provider reported the patient is surgical candidate for the right knee as MRI of the right knee revealed a meniscal tear. The provider documents upon physical exam of the patient's right knee, tenderness along the knee joint bilaterally, medially, and greater than laterally. The provider documented mild laxity to anterior drawer testing at 1+. The patient has weakness against resistance to hip flexion, knee flexion, and knee extension bilaterally at 5-/5. The provider also documented pain along the bottom of the foot without swelling present. The provider administered a hinged knee brace and prescriptions for the following medications, Tramadol, Flexeril, Gabapentin, Acetadryl, LidoPro lotion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro replacement hinged right knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Knee & Leg (Acute & Chronic. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2004, Chapter 13 and the Official Disability Guidelines, Treatment Index, 9th Edition, TWC Guidelines Web

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Knee and Leg Chapter

Decision rationale: The current request is not supported as Official Disability Guidelines indicate custom fabricated knee braces may be appropriate for patients with the following conditions: abnormal limb contour, skin changes, severe osteoarthritis, maximal offloading of painful repaired knee compartment, and severe instability as noted on physical examination of the knee. The patient does not meet the above criteria; therefore, the requested durable medical equipment is not indicated. As such, the request for replacement hinged right knee brace is not medically necessary or appropriate.