MAXIMUS Federal Services

Case Number:	CM13-0055792		
Date Assigned:	12/30/2013	Date of Injury:	03/25/2011
Decision Date:	03/13/2014	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/21/2013

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 Physical Medicine and Rehabilitation 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 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:

This 56 year-old female sustained an injury on 3/25/11 while employed by [redacted]. The request under consideration includes an initial post-operative chiropractic therapy for the left knee two times a week times for three weeks and a home exercise kit. The report of 8/23/13 from [redacted] noted that the patient had complaints of constant severe low back pain that radiates into both legs; bilateral knee pain aggravated by walking and standing long periods. An exam of the knees showed mild swelling on the left; 3+ spasm, tenderness to medial aspect on right and left anterior joint line on left; positive Drawer and McMurray's on right. An exam of lumbar spine showed tenderness and 3+ spasm; positive Kemp's & Yeoman's bilaterally. Diagnoses included chondromalacia patella; lumbar spondylosis with myelopathy; sciatica; knee bursitis; myofascitis; lateral meniscus tear bilateral knee; and cruciate tear of the right. The treatment plan included: a left knee arthroscopic surgery by [redacted] on 7/18/13 and cleared to start post-operative physical therapy; ordering home exercise kit and cold/heat device for left knee; and chiropractic manipulative therapy. The requests above were non-certified on 9/10/13 and again on appeal on 10/30/13, citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Initial post-operative chiropractic therapy for the left knee two (2) times a week for three (3) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 339. Decision based on Non-MTUS Citation ODG-TWC Knee and Leg Procedure Summary (last updated 06/07/2013)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

Decision rationale: The Chronic Pain Guidelines indicate that manual therapy and manipulation is not recommended for the knees. [redacted] has not submitted reports to support for this treatment outside the recommendations of the guidelines for this patient with post arthroscopic knee surgery on 07/18/13, and participation in a physical therapy program, as recommended by the orthopedist. The initial post-op chiropractic therapy for the left knee two (2) times a week for three (3) weeks is not medically necessary and appropriate.

Home exercise kit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Durable medical equipment (DME), pages 297-298, 309

Decision rationale: The Official Disability Guidelines indicate that a home exercise kit is recommended as an option. Although the guidelines recommend daily exercises, submitted reports have not demonstrated any evidence to support the medical necessity for a home exercise kit versus simple inexpensive resistive therabands to perform isometrics and eccentric exercises. Exercise equipment is considered not primarily medical in nature and could withstand repeated use as rental or used by successive patients, which is not indicated here. The patient continues to participate in active physical therapy and should have received instructions for an independent home exercise program without the need for specialized equipment. The home exercise kit is not medically necessary and appropriate.

Cold/heat device: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Knee and Leg Procedure Summary (last updated 06/07/2013)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Continuous-Flow Cryotherapy, page 292

Decision rationale: The Official Disability Guidelines specifically addresses the short-term benefit of cryotherapy post knee surgery; however, limits the use for 7-day post-operative period as efficacy has not been proven after. Submitted reports have not demonstrated medical

necessity outside the guideline criteria, as the patient underwent a left knee arthroscopic surgery by [redacted] on 7/18/13. Submitted reports have not demonstrated the necessity outside the recommendations of the guidelines. The cold/heat device is not medically necessary and appropriate.