MAXIMUS Federal Services

Case Number:	CM13-0056676		
Date Assigned:	12/30/2013	Date of Injury:	07/23/2007
Decision Date:	03/27/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/22/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Expert reviewer is licensed in Chiropractor 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 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/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:

Patient is a 48-year-old male who sustained an unspecified injury on 07/23/2007. On 07/05/2013, the patient underwent a right medial and lateral meniscectomy, tricompartmental chondroplasty, tricompartmental synovectomy, ACL tightening with ArthroCare wand, and a right knee injection. The patient was re-evaluated on 08/13/2013 for complaints of right knee pain 7/10 and left knee pain 7/10. The patient additionally complained of neck pain rated 8/10 and low back pain rated 7/10. Upon evaluation of the right knee, the patient had noted atrophy of his right quadricep and slight effusion was noted over the patient's right knee. Physical examination further noted the patient had decreased range of motion, and decreased motor strength. The assessment of the right knee was noted as right knee medial meniscus tear. The treatment plan was to request immediate schedule for the patient post-op physical therapy directed to the patient's right knee at a frequency of 3 times per week for 4 weeks due to limited range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for Chiropractic Care for the Right Knee 2 times 8: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

Decision rationale: The request for chiropractic care for the right knee 2 times 8 is non-certified. The patient was documentation to have decreased range of motion pain to the right knee. The treatment plan was noted to request physical therapy to be directed at the patient's right knee. Furthermore, the Chronic Pain Medical Treatment Guidelines do not recommend manual therapy and manipulation for the knee. As the requested service was not part of the treatment plan and the Chronic Pain Medical Treatment Guidelines do not recommend the use of chiropractic care for knees the request is not supported. Given the information submitted for review, the request for chiropractic care for the right knee 2times 8 is non-certified.