

Case Number:	CM14-0006468		
Date Assigned:	01/24/2014	Date of Injury:	02/24/2011
Decision Date:	08/11/2014	UR Denial Date:	01/08/2014
Priority:	Standard	Application Received:	01/16/2014

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. The expert 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 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:

The injured worker is a 54 year old male who reported an injury on 02/24/2011. The mechanism of injury was a fall. The injured worker was diagnosed with internal derangement of the knee. The injured worker complained of right knee pain rated at 7/10 and left knee pain rated at 5/10. His physical examination revealed moderate effusion of the right knee, tenderness over the medial and lateral joint line of the right knee, and crepitus of the bilateral knees with motion. He was also noted to have decreased right knee range of motion, a post patellofemoral grind test bilaterally, and positive valgus stress testing on the right. His previous treatments were noted to include right knee surgery, medications, and Synvisc injections. An MRI of the left knee, performed on 12/11/2013, revealed evidence of tricompartmental osteoarthritic change and an oblique tear of the posterior horn of the medial meniscus. On 1/16/14, a request for Aquatic Therapy 2 times per week for 3 weeks had been made. However, a rationale for the requested treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

AQUATIC THERAPY 2 TIMES PER WEEK FOR 3 WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: According to the MTUS Chronic Pain Guidelines, aquatic therapy is an optional form of exercise therapy that is specifically recommended where reduced weight-bearing is desirable. The documentation submitted for review indicated the patient was previously approved for six sessions of aquatic therapy. However, in the absence of details regarding previous therapy, such as objective functional gains made throughout those therapy sessions, the request for additional therapy is not supported. Therefore, the request is not supported. As such, the request is not medically necessary and appropriate.