

<b>Case Number:</b>	CM14-0019494		
<b>Date Assigned:</b>	04/23/2014	<b>Date of Injury:</b>	08/05/2010
<b>Decision Date:</b>	07/03/2014	<b>UR Denial Date:</b>	01/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/14/2014

### 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 & Rehabilitation, has a subspecialty in Sports Medicine 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:

The injured worker is a 44-year-old male who reported an injury on 08/05/2010 after he fell from a forklift from approximately 5 feet. The injured worker's treatment history included knee arthroscopy for the anterior cruciate ligament reconstruction on 11/14/2011. The injured worker's postoperative care included physical therapy and medications. The injured worker was evaluated on 12/09/2013. It was documented the injured worker had continuous left knee pain with mechanical symptoms rated at an 8/10 to 9/10. The injured worker had left knee range of motion described as 5 degrees in extension to 110 degrees in flexion with no evidence of medial joint line tenderness or patellar tracking. The injured worker's treatment recommendations included durable medical equipment to include heat and cold packs, and a home exercise kit for the left patella.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**KNEE HOME EXERCISE REHAB KIT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EXERCISE Page(s): 46.

**Decision rationale:** The requested knee home exercise rehab kit is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has deficits that would benefit from an active therapy program. Due to the extent of the injury and surgical intervention, the injured worker should be well versed in a home exercise program. California Medical Treatment Utilization Schedule does not recommend 1 exercise program over another. There is no documentation that the injured worker has failed to progress through a traditional self-managed and self-directed home exercise program and would benefit from the addition of durable medical equipment to include a home exercise kit. There is no justification provided within the documentation to support the need for additional equipment to assist the injured worker in participating in a home exercise program. As such, the requested knee home exercise rehab kit is not medically necessary or appropriate.