MAXIMUS Federal Services

Case Number:	CM14-0064703		
Date Assigned:	07/11/2014	Date of Injury:	03/04/2010
Decision Date:	09/16/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	05/07/2014

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 Nevada. 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 records presented for review indicate that this 63 year-old individual was reportedly injured on 3/4/2010. The mechanism of injury is not listed. The most recent progress note dated 1/23/2014 indicates that there are ongoing complaints of neck, right shoulder, low back, left knee, and right foot pain. The physical examination demonstrated cervical spine: positive tenderness to palpation over the paraspinal muscles. The cervical spine has restricted range of motion. Lumbar spine: positive tenderness to palpation with palpable spasm over the paraspinal muscles. The lumbar spine has restricted range of motion. Right shoulder: positive tenderness to palpation with no palpable spasm. The right shoulder has restricted range of motion. Left knee: positive tenderness to palpation with no spasm. The left knee has full range of motion. Right foot: tenderness to palpation. The right foot has full range of motion. Diagnostic imaging studies mentioned pending results of an MRI to the left knee. Previous treatment includes medications, and conservative treatment. A request had been made for hinged brace for left knee, lumbar spine support, and was not certified in the pre-authorization process on 4/9/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hinged Brace for Left Knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 1021-1022. Decision based on Non-MTUS Citation Official Disability Guidelines Knee and Leg (updated 3/31/14), Knee Brace.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Acute, Sub-Acute and Chronic Knee disorders (Insufficient Evidence (I).

Decision rationale: According to ACOEM guidelines a brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability although its benefits may be more emotional (i.e., increasing the patient's confidence) than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program. After reviewing the medical documentation provided there was no instability noted on physical exam. Therefore, this request is deemed not medically necessary.

Support for Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): (electronically sited).

Decision rationale: ACOEM treatment guidelines do not support the use of a LSO or other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The claimant is currently not in an acute postoperative setting and there is no documentation of instability or spondylolisthesis with flexion or extension plain radiographs of the lumbar spine. As such, this request is not considered medically necessary.