MAXIMUS Federal Services

Case Number:	CM14-0077277		
Date Assigned:	08/08/2014	Date of Injury:	05/14/2012
Decision Date:	09/15/2014	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	05/27/2014

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 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 63 year old female whose date of injury is 05/14/12. On this date the injured worker was assisting a client and injured the left knee. Prior conservative treatment includes medication management, physical therapy, cortisone injections, left knee arthroscopy on 12/14/13 and knee brace. The injured worker has been authorized for left knee meniscectomy for repair of the lateral meniscus with 6 postoperative work conditioning/hardening visits. Progress report dated 07/02/14 indicates that the injured worker complains of constant moderate pain in the left knee. Neurological examination of the lower extremities is within normal limits bilaterally. Diagnoses are tearing of medial meniscus of right knee, tear of lateral meniscus of left knee, bursitis and tendinitis of the left shoulder, partial tear of rotator cuff tendon, and bursitis of the right knee. This note states that the injured worker has completed a work hardening program and reached a plateau in recovery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post Operative Work Conditioning/ Hardening: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 125. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work hardening/work conditioning Page(s): 125-126.

Decision rationale: Based on the clinical information provided, the request for postoperative work conditioning/hardening is not recommended as medically necessary. First, the request is nonspecific as work conditioning and work hardening are two different types of programs. Second, the injured worker has previously completed a work hardening program. The authorization determination indicates that further authorization will require documented objective evidence of derived functional benefit. There are no objective measures of improvement documented to establish efficacy of treatment in accordance with California Medical Treatment Utilization Schedule guidelines. Note dated 07/02/14 indicates that the injured worker has completed a work hardening program and reached a plateau in recovery.

Post Operative Follow Up Visit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM - CHAPTER 7 -PG 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Office visits.

Decision rationale: Based on the clinical information provided, the request for postoperative follow up visit is not recommended as medically necessary. There is no clear rationale provided to support the requested follow up visit at this time. It appears from the submitted clinical records that the injured worker has reached a plateau in recovery. Therefore, medical necessity cannot be established in accordance with the Official Disability Guidelines.

ROM Measurement: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Computerized muscle testing.

Decision rationale: Based on the clinical information provided, the request for range of motion measurement is not recommended as medically necessary. There is no clear rationale provided to support this request as a separate evaluation. Current evidence based guidelines note that range of motion and muscle testing should be performed as part of a history and physical examination. Therefore, medical necessity is not established in accordance with the Official Disability Guidelines.

Addressing ADLs, Self Care/ Home Management Training: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Exercise.

Decision rationale: Based on the clinical information provided, the request for addressing activities of daily living, self-care/home management training is not recommended as medically necessary. The Official Disability Guidelines note that home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program. The injured worker has undergone physical therapy as well as a work hardening program and should be well-versed in a home exercise program at this time. Therefore, medical necessity is not established.

Durable Medical Equipment (DME) - Electrical Stimulation to Left Knee (Unattended): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Electrical stimulators (E-stim).

Decision rationale: Based on the clinical information provided, the request for durable medical equipment-electrical stimulation to the left knee (unattended) is not recommended as medically necessary. The request is nonspecific and does not indicate the frequency and duration of requested treatment. There are no specific, time-limited treatment goals provided. The Official Disability Guidelines note that interferential current therapy is under study for osteoarthritis and recovery post knee surgery.

Durable Medical Equipment (DME) -Infared to Left Knee: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin, Infrared Therapy.

Decision rationale: The request is nonspecific and does not indicate the frequency and duration of requested treatment. There are no specific, time-limited treatment goals provided. California Medical Treatment Utilization Schedule, American College of Occupational and Environmental Medicine and the Official Disability Guidelines do not address infrared therapy to the knee and leg. Aetna considers treatment with low-level infrared light (infrared therapy, Anodyne Therapy System) experimental and investigational for the treatment of the following indications because of a lack of adequate evidence in the peer-reviewed published medical literature regarding the

effectiveness of infrared therapy for these indications: Acne, Bell's palsy, Central nervous system injuries, Chronic non-healing wounds, Diabetic macular edema, Diabetic peripheral neuropathy, Ischemic stroke, Lymphedema, Neck pain, Osteoarthritis, Parkinson's disease, Retinal degeneration and stroke. Based on the clinical information provided, the request for durable medical equipment infrared to left knee is not recommended as medically necessary.