

Case Number:	CM14-0190221		
Date Assigned:	11/18/2014	Date of Injury:	01/03/2014
Decision Date:	01/09/2015	UR Denial Date:	11/07/2014
Priority:	Standard	Application Received:	11/11/2014

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, has a subspecialty in Interventional Spine 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 patient is a 42 year old male with an injury date of 01/03/14. Based on the 06/30/14 progress report provided by treating physician, the patient complains of left knee pain. He is status post left knee arthroscopy on 04/17/14. Patient limps and favors left knee. Physical examination to the left knee revealed well-healed scars, jointline tenderness, crepitation and patellofemoral pain. Range of motion was 0 to 120 degrees. Per progress report dated 03/21/14, patient has had 6 sessions of physical therapy prior to left knee operation. Per progress report dated 09/19/14, "patient did receive home exercise kit and the interferential unit. However, therapy and acupuncture treatment has not been authorized." Patient is temporarily totally disabled. Diagnosis 03/21/14- left knee complex medial meniscus tear Diagnosis 06/30/14- status post left knee arthroscopy 04/17/14 with residual patellofemoral pain and severe atrophy The utilization review determination being challenged is dated 11/07/14. Treatment reports were provided from 02/25/14 - 10/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY FOR LEFT KNEE (2X6) 12 SESSIONS: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS post-surgical guidelines, Knee Page(s): 24-25.

Decision rationale: The patient is status post left knee arthroscopy on 04/17/14 and presents with residual left knee pain. The request is for physical therapy for left knee two times six 12 sessions. Patient limps and favors left knee. Physical examination to the left knee 06/30/14 revealed well-healed scars, joint line tenderness, crepitation and patellofemoral pain. Range of motion was 0 to 120 degrees. Per progress report dated 03/21/14, patient has had 6 sessions of physical therapy prior to left knee operation. Patient is temporarily totally disabled. California MTUS post-surgical guidelines, pages 24-25, Knee (MTUS post-surgical p 24, 25) Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5): Post surgical treatment: (Meniscectomy): 12 visits over 12 weeks*Postsurgical physical medicine treatment period: 6 months Patient is within postoperative time period of 6 months. Left knee arthroscopy 04/17/14 and UR date of 11/07/14, which states "... no documentation of how many sessions of physical therapy this claimant has completed postoperatively..." Per progress report dated 09/19/14, "patient did receive home exercise kit and the interferential unit. However, therapy and acupuncture treatment has not been authorized." It does not appear patient had postoperative physical therapy. The request for 12 sessions is within guideline recommendation. The request is medically necessary.

ACUPUNCTURE FOR LEFT KNEE (1X6) 6 SESSIONS: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guidelines Page(s): 13 OF 127.

Decision rationale: The patient is status post left knee arthroscopy on 04/17/14 and presents with residual left knee pain. The request is for acupuncture for left knee (one times six) six sessions. Patient limps and favors left knee. Physical examination to the left knee 06/30/14 revealed well-healed scars, jointline tenderness, crepitation and patellofemoral pain. Range of motion was 0 to 120 degrees. Per progress report dated 03/21/14, patient has had 6 sessions of physical therapy prior to left knee operation. Acupuncture Medical Treatment Guidelines. MTUS pg. 13 of 127 states: " (i) Time to produce functional improvement: 3 to 6 treatments (ii) Frequency: 1 to 3 times per week (iii) Optimum duration: 1 to 2 months(D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)." Treater has not provided reason for the request. When reading MTUS for acupuncture, prior response to therapy is not pre-requisite to a trial of acupuncture. MTUS allows for a trial of acupuncture up to 6 sessions and more if functional improvement is demonstrated. Review of medical records do not show that patient tried acupuncture in the past. The request is medically necessary.3. Home Exercise Kit for left knee is medically necessary and appropriate.

HOME EXERCISE KIT FOR LEFT KNEE: Overturned

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 Official Disability Guidelines (ODG) Knee chapter, under exercise kit

Decision rationale: The patient is status post left knee arthroscopy on 04/17/14 and presents with residual left knee pain. The request is for home exercise kit for left knee. Patient limps and favors left knee. Physical examination to the left knee 06/30/14 revealed well-healed scars, jointline tenderness, crepitation and patellofemoral pain. Range of motion was 0 to 120 degrees. Per progress report dated 03/21/14, patient has had 6 sessions of physical therapy prior to left knee operation. Official Disability Guidelines (ODG) guidelines Knee chapter, under exercise kit: "Recommended as an option. See Exercise, where home exercise programs are recommended; & Physical medicine treatment, where active self-directed home physical therapy is recommended." Treater has not discussed reason for the request in the reports provided but ODG does supports exercise kit for the knee. It would appear that this kit was already provided to the patient. The request is medically necessary.

IF UNIT FOR LEFT LEG AND KNEE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The patient is status post left knee arthroscopy on 04/17/14 and presents with residual left knee pain. The request is for IF UNIT FOR LEFT LEG AND KNEE. Patient limps and favors left knee. Physical examination to the left knee 06/30/14 revealed well-healed scars, joint line tenderness, crepitation and patellofemoral pain. Range of motion was 0 to 120 degrees. Per progress report dated 03/21/14, patient has had 6 sessions of physical therapy prior to left knee operation. California MTUS (p118-120) states "Interferential Current Stimulation (ICS) Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine:- Pain is ineffectively controlled due to diminished effectiveness of medications; or- Pain is ineffectively controlled with medications due to side effects; or- History of substance abuse; or- Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or- Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)Treater has not discussed reason for the request in the reports provided. Treater has not mentioned whether the request is for rental or purchase. Per progress report dated 09/19/14, "patient did receive home exercise kit and the interferential unit." It would appear that the patient was already provided with an interferential unit. However, MTUS supports 30-day trial before a home unit is recommended. A successful trial with pain reduction and functional improvement is required if indicated. Given that the patient has not trialed a 30-day home use, the request for home unit is not medically necessary.

