

Case Number:	CM14-0195846		
Date Assigned:	12/03/2014	Date of Injury:	04/21/2014
Decision Date:	01/26/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/21/2014

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 Orthopedic Surgery 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 claimant is a 61 year old female with an industrial injury dated 04/21/14. Exam note dated 10/21/14 states the patient returns with right wrist pain. Conservative treatments have included physical therapy, Ibuprofen, and splints. The patient explains the current pain as sharp and constant. The patient also experiences crepitus and pain in the shoulder, neck, and right knee. Upon physical exam the patient demonstrates a normal gait without assistive device. Range of motion for the wrist was noted as an extension/flexion of 62/60 on the right. Radial/Ulnar deviation on the right was noted as 30/35. X-ray of the wrist reveals a negative ulnar variance of approximately 1mm, and a lunate volar orientation of 12' and a scaphoid inclination of 50'. MRI of the upper extremity reveals slight speckled tendinosis of the external carpal ulnar tendon. The diagnosis is noted as tendinitis of the wrist. Treatment includes a steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Operative Physical Therapy two times a week for six weeks for the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: According to the California MTUS Postsurgical Treatment Guidelines, Knee Meniscectomy, page 24, twelve (12) visits of therapy are recommended after arthroscopy with partial meniscectomy over a 12-week period. The guidelines recommend initially half of the 12 visits to be performed. The request exceeds the initial allowable visits. Therefore, the request for post-operative physical therapy two times a week for six weeks for the right knee is not medically necessary.