

Case Number:	CM14-0196393		
Date Assigned:	12/03/2014	Date of Injury:	04/18/2014
Decision Date:	01/15/2015	UR Denial Date:	10/21/2014
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 Internal Medicine 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 injured worker (IW) is a 43-year old man who sustained an injury to his left knee on April 18, 2014 as a result of a motor vehicle accident. He has been diagnosed with fracture of the left tibia and cruciate ligament sprain of the left knee. The IW has been evaluated with CT and x-rays, which reportedly revealed the impaction fracture. Treatments have consisted of activity restrictions, assistive devices, casting/splinting, ice application, physical therapy, and home exercise program. The IW was evaluated for functional improvement on August 4, 2014. The evaluation was performed using an external Goniometer or digital protractor. This is pursuant to the UR documentation. There was increased range of motion on the left knee flexion from 84 degrees to 100 degrees since the July 7, 2014 assessment. Left knee extension was 0 degrees, external rotation was 20 degrees, and internal rotation was 15 degrees. Per the October 1, 2014 follow-up, the IW complained of intermittent moderate to severe left knee pain. Examination revealed 2+ spasm and tenderness of the left anterior joint line and popliteal fossa, and positive posterior-anterior drawer test. Goniometer measurement during this visit was unchanged compared to the August 4, 2014 evaluation. The IW has participated in 18 physical therapy sessions and reached a plateau in his recovery. He is release to work with restrictions of no kneeling or squatting as well as no lifting greater than 25 pounds. A plan for work hardening was noted. The treating physician is requesting authorization for follow-up visit with range of motion measurement and addressing activities of daily living.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Follow up visit with range of motion measurement and addressing activities of daily living: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Worker's Compensations, Online Edition, Knee & Leg Chapter, Office Visits

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, one follow-up visit with range of motion measurement and addressing activities of daily living are not medically necessary. The ACOEM guidelines state knee examinations should be performed in a thorough and careful manner in order to identify any clinically significant pathology that may be present. See Focused Knee Examination Section Chapter 13 of the ACOEM for additional details. Office visits/evaluation and management visits play a critical role in the proper diagnosis and return to function and should be encouraged. The need for clinical office visit is individualized and based upon patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. In this case, the injured worker is a 43-year-old man with a date of injury April 18, 2014. There was a single progress note in the medical record dated October 1, 2014. According to the utilization review, the injured worker sustained a fracture of left tibia and cruciate ligament sprain of left knee. The injured worker was evaluated for functional improvement on August 4, 2014. Examination included an external goniometer (for range of motion). There was increased range of motion when compared to the July 7, 2014 assessment. Functional improvement was also noted by increased activities of daily living (walking 45 minutes with less pain). The worker was counseled on home management training regarding activities of daily living and compensatory training. On October 1, 2014 the treating physician performed a goniometer measurement that was unchanged when compared to the August 4, 2014 evaluation. He participated in 18 sessions of physical therapy and reached a plateau in recovery. The injured worker returned to work with restrictions in terms of no kneeling or squatting and no lifting greater than 25 pounds. While range of motion measurement is helpful for following recovery, the measurements are part of the physical examination for this complaint. Consequently, absent additional documentation and a clinical indication to support serial goniometer measurements, range of motion measurement may be performed as part of the physical examination. Based on the clinical information in the medical record and a peer-reviewed evidence-based guidelines, one follow-up visit with range of motion measurement and addressing activities of daily living are not medically necessary.