

Case Number:	CM15-0133622		
Date Assigned:	07/21/2015	Date of Injury:	04/23/1999
Decision Date:	08/19/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/10/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 52-year-old female who sustained an industrial injury on 4/23/99. The mechanism of injury was not documented. Past medical history was positive for hypertension, hepatitis, high cholesterol, and hypothyroidism. Past surgical history was positive for L3/4 and L4/5 lumbar laminectomy on 11/14/95, and L4/5 and L5/S1 lumbar fusion on 1/17/02. The 11/12/12 right elbow ultrasound documented very mild thickening and inflammation of the right olecranon bursa, and very mild arthritic changes on the posterior aspect of the right elbow on the ulnohumeral region. The 6/14/14 left knee MRI documented a horizontal cleavage tear of the body of the lateral meniscus and a small Baker's cyst. The progress reports dated 9/10/14, 10/8/14, and 11/12/14 documented a diagnosis of lateral and/or medial epicondylitis with the treatment plan recommending physical therapy, acupuncture, and home exercise program. The 5/29/15 treating physician report cited constant grade 9/10 right elbow pain radiating up into the shoulder and down into the hands with numbness and tingling. She also reported constant grade 8-9/10 left knee pain with associated giving way and weakness. She was attending physical therapy 2 times per week. Physical exam documented loss of residual terminal right elbow range of motion with tenderness at the radial head and capitellar area with some crepitus. She had tenderness and spasms of the left knee medial joint line. The diagnosis included internal derangement left knee with mechanical symptomatology and a recent fall, and right elbow sprain/strain rule-out radial head fracture. The treatment plan recommended proceeding with left knee surgery. The injured worker can combine physical therapy for her elbow and both knees thereafter. In the meantime, terminal extension and flexion, as well as pronation and supination

of the right elbow was somewhat restricted and physical therapy for the elbow was indicated. Authorization was requested for left knee arthroscopy, physical therapy 3 times per week for 6 weeks for the right elbow, cold therapy unit for 30 days rental, and post-operative physical therapy for 24 visits for the left knee. The 6/19/15 utilization review certified the left knee arthroscopy. The request for physical therapy 3 times per week for 6 weeks for the right elbow was non-certified as the injured worker had been attending physical therapy with the amount of treatment rendered to date and specific response to that therapy was not documented. The request for cold therapy unit for 30 days rental was modified to 7 days consistent with the Official Disability Guidelines. The request for post-operative physical therapy x 24 visits for the left knee was modified to 6 visits consistent with the Post-Surgical Treatment Guidelines for initial post-operative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3x/week for 6 weeks for the right elbow: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 25-26 Chronic Pain Treatment Guidelines Introduction, Physical Medicine Page(s): 9, 98-99.

Decision rationale: The California MTUS guidelines recommend physical therapy for epicondylalgia state that it is reasonable to expect that if a particular treatment is going to benefit a particular patient, beneficial effects should be evident within 2-3 visits. Continuing with a treatment that has not resulted in objective improvement is not reasonable. Treatment that has not resulted in improvement after a couple of visits should either be modified substantially or discontinued. It should be expected that most patients with more severe conditions receive 8-12 visits over 6-8 weeks, as long as functional improvement and program progression are documented. In general, the MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. Guideline criteria have not been met. This injured worker presents with persistent right elbow pain. Records suggest that physical therapy is ongoing. There is no documentation of specific functional treatment goals for the requested physical therapy. There is no functional assessment or specific functional deficit identified. There is no documentation relative to the number of physical therapy sessions this injured worker has attended for her elbow complaints or what, if any, functional benefit has been achieved with that treatment. This request markedly exceeds guideline recommendations. There is no compelling rationale presented to support the medical necessity of additional supervised treatment over an independent home exercise program. Therefore, this request is not medically necessary.

Associated Surgical Service: Cold Therapy Unit for 30 days rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee & Leg (updated 05/05/15).

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: Continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following knee surgery. The 6/19/15 utilization review decision recommended partial certification of a cryotherapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.

Associated Surgical Service: Post-operative Physical Therapy for 24 visits for the left knee: Upheld

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

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

Decision rationale: The California Post-Surgical Treatment Guidelines for meniscectomy suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 6 visits. If it is determined additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The 6/19/15 utilization review recommended partial certification of 6 initial post-op physical therapy visits consistent with guidelines. There is no compelling reason submitted to support the medical necessity of care beyond guideline recommendations and the care already certified. Therefore, this request is not medically necessary.