MAXIMUS Federal Services

Case Number:	CM15-0183436		
Date Assigned:	09/24/2015	Date of Injury:	02/25/2015
Decision Date:	11/06/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/17/2015

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: Texas, California
Certification(s)/Specialty: Family Practice

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 66-year-old female, who sustained an industrial injury on 2-25-15. The injured worker is undergoing treatment for cervical and lumbar radiculopathy, shoulder impingement and knee tend-burs. Medical records dated 7-30-15 indicate the injured worker complains of back and right knee pain. She reports difficulty with prolonged standing, sitting, walking, squatting, kneeling and stooping. Physical exam dated 7-30-15 notes antalgic gait and ambulation with use of a cane, tenderness to palpation, spasm and guarding of the lumbar paravertebral area, decreased range of motion (ROM) and decreased sensation. There is right knee tenderness to palpation with decreased strength and crepitus. A 6-2015 magnetic resonance imaging (MRI) was reviewed indicating meniscal tear and evidence of a previous partial meniscectomy. A 7-17-15 lumbar magnetic resonance imaging (MRI) indicates disc herniation, degenerative changes and disc bulges. Treatment to date has included knee surgery, physical therapy and medication. The original utilization review dated 8-17-15 indicates the request for right knee post-operative physical therapy X18 is modified to right knee post-operative physical therapy X12 noting guidelines recommend up to 12 physical therapy post meniscectomy sessions and lumbar corset is non-certified noting guidelines specifically indicate that the use of lumbar supports is not recommended for prevention. The patient sustained the injury due to a fall. The medication list includes Ibuprofen, Zofran, Propranolol, Vivelle, Cyclobenzaprine and Prometrium.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee Post Operative Physical Therapy x 18 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Knee.

Decision rationale: Request Right knee Post Operative Physical Therapy x 18 sessions. CA MTUS Post-Surgical Rehabilitation guidelines cited below recommend 12 visits over 12 weeks. This is a request for Right knee Post Operative Physical Therapy x 18 sessions. Therefore the requested PT visits are more than the recommend by the cited guideline. Treatment to date has included knee surgery, physical therapy and medication. Exact date of the right knee surgery was not specified in the records specified. An operative note of the right knee surgery was not specified in the records specified. The patient had received an unspecified number of the PT visits for an injury. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Previous PT visits notes were not specified in the records provided. In addition as per cited guideline, "Patient education regarding postsurgical precautions, home exercises, and self-management of symptoms should be ongoing components of treatment starting with the first visit. Intervention should include a home exercise program to supplement therapy visits". Frequency of visits shall be gradually reduced or discontinued as the patient gains independence in management of symptoms and with achievement of functional goals. A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program for the right knee is not specified in the records provided. The medical necessity of the request for Right knee Post Operative Physical Therapy x 18 sessions is not medically necessary in this patient.

Lumbar Corset: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back, Lumbar supports.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 09/22/15) Lumbar supports.

Decision rationale: Lumbar Corset. Per the ACOEM guidelines cited below, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." In addition per the ODG cited below regarding lumbar supports/brace, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative

option). Under study for post-operative use, see Back brace, post operative (fusion). Patient has received an unspecified number of PT visits for this injury. Response to prior conservative therapy was not specified in the records provided. Prior conservative therapy notes were not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. There is no evidence of instability, spondylolisthesis, lumbar fracture or recent lumbar surgery. Surgery or procedure note related to this injury was not specified in the records provided. The medical necessity, of Lumbar Corset is not fully established.