

Case Number:	CM15-0087023		
Date Assigned:	05/11/2015	Date of Injury:	12/26/2012
Decision Date:	06/10/2015	UR Denial Date:	04/23/2015
Priority:	Standard	Application Received:	05/06/2015

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:

The injured worker is a 68-year-old male who sustained an industrial injury on 12/26/12. Injury occurred when he slipped in the bathroom with immediate onset of left knee pain and dysfunction. The 8/26/14 left knee MRI impression documented no definite evidence of meniscal tearing, and intact collateral and cruciate ligaments. He was diagnosed with patellofemoral malalignment. The injured worker underwent left knee arthroscopy with lateral release, removal of loose body, meniscectomy, and synovectomy on 2/3/15. Records documented that he had been approved for 12 post-operative physical therapy sessions. The 2/25/15 initial physical therapy report indicated he had a mild limp involving the left lower extremity. The lower extremity knee was moderately swollen with portals closed and healing. Range of motion was moderately limited, due to knee swelling. He was able to perform a quad set with posterior knee support. The treatment plan documented instruction in standing weight shifting, heel raises, and gentle quad sets with posterior knee support. The treatment plan was 3 times per week for 4 weeks. Chart notes documented 8 visits were provided as of 4/10/15, with no documentation of objective exam findings. Continued exercise was noted. Home exercise instruction was documented. The 4/9/15 treating physician report cited continued grade 6/10 left knee pain, improved since his last visit. Physical exam documented joint tenderness, and limited range of motion. There was slight improvement. X-rays showed no increase in osteoarthritis. The treatment plan recommended additional physical therapy 3x4 to regain strength and improve range of motion. An IF unit was requested for 30-60 day rental and purchase if effective, to manage pain and reduce medication usage. He remained off work. The 4/24/15 utilization review non-certified the request for

physical therapy 3x4 for the left knee as there was no clear functional improvement documented relative to previous physical therapy, and no indication that the injured worker completed all authorized therapy. The request for an IF unit and supplies for 30-60 day rental and purchase was non-certified as there was no indication that guidelines criteria had been met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, 3 times per wk for 4 wks (12 sessions), Left Knee: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

Decision rationale: The California Post-Surgical Treatment Guidelines for chondroplasty suggest a general course of 12 post-operative visits over 12 weeks during the 6-month post-surgical treatment period. If it is determined that 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. Guideline criteria have not been met. This patient underwent left knee arthroscopic surgery on 2/3/15 with 12 post-operative physical therapy visits certified. Records suggest that 8 had been completed but there is no documentation of objective measurable function improvement with care to date. There is no current documentation of specific objective functional deficits to be addressed by additional physical therapy. There is no compelling rationale presented to support the medical necessity of additional supervised physical therapy over an independent home exercise. There are no clinical findings that would support an exception to guidelines. Therefore, this request is not medically necessary.

IF (interferential) unit & supplies, 30-60 day rental/ purchase: Upheld

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

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

Decision rationale: The California MTUS guidelines do not recommend interferential current (IFC) stimulation as an isolated intervention. Guidelines indicate that IFC is possibly appropriate if pain is ineffectively controlled due to diminished effectiveness of medications or due to medication side effects, there is a history of substance abuse, significant post-operative pain limits ability to perform exercise/physical therapy treatment, or the patient is unresponsive to conservative measures. If those criteria are met, then a one-month trial may be appropriate to study effects and functional benefit. Guideline criteria have not been met. There is no evidence that the patient has failed to benefit from medications or conservative treatment. There is no indication that post-operative pain prohibits participation in exercise or physical therapy.

Additionally, the request for purchase of an IFC unit exceeds guidelines recommendations. Therefore, this request is not medically necessary.