

Case Number:	CM15-0087262		
Date Assigned:	05/11/2015	Date of Injury:	01/03/2014
Decision Date:	06/16/2015	UR Denial Date:	05/01/2015
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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 63 year old male injured worker suffered an industrial injury on 01/03/2014. The diagnoses included left knee meniscal tear. The injured worker had been treated with arthroscopy. On 4/22/2015 the treating provider reported left knee arthroscopy on 4/8/2015. She reported having no pain and significant increase in the range of motion. On exam there was tenderness with crepitus and left thigh muscle weakness. The treatment plan included Brace wrap around hinged left knee brace and Post-op physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Brace wrap around hinged left knee brace: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation KNEE BRACE <http://www.odg-twc.com/index.html>.

Decision rationale: Recommended as indicated below. Recommend valgus knee braces for knee OA. Knee braces that produce a valgus moment about the knee markedly reduce the net knee adduction moment and unload the medial compartment of the knee, but could be impractical for many patients. There are no high quality studies that support or refute the benefits of knee braces for patellar instability, ACL tear, or MCL instability, but in some patients a knee brace can increase confidence, which may indirectly help with the healing process. In all cases, braces need to be used in conjunction with a rehabilitation program and are necessary only if the patient is going to be stressing the knee under load. (Bengal, 1997) (Crossley, 2001) (Dhondt-Cochrane, 2002) (Miller, 1997) (Yeung-Cochrane, 2002) (Van Tiggelen, 2004) There are no data in the published peer-reviewed literature that shows that custom-fabricated functional knee braces offer any benefit over prefabricated, off-the-shelf braces in terms of activities of daily living. (BlueCross BlueShield, 2004) The use of bracing after anterior cruciate ligament (ACL) reconstruction cannot be rationalized by evidence of improved outcome including measurements of pain, range of motion, graft stability, or protection from injury. (Wright, 2007) Among patients with knee OA and mild or moderate valgus or varus instability, a knee brace can reduce pain, improve stability, and reduce the risk of falling. (Zhang, 2008) Patellar taping, and possibly patellar bracing, relieves chronic knee pain, according to a recent meta-analysis. Patellar taping may be preferred over bracing due to the fact that there is much more evidence for taping than bracing, and also because taping produces better clinical results in terms of reductions in pain than patellar bracing, plus patients are more active in their rehabilitation with taping than with bracing. (Warden, 2008) This study recommends the unloader (valgus) knee brace for pain reduction in patients with osteoarthritis of the medial compartment of the knee. (Gravlee, 2007) Evidence that knee braces used for the treatment of osteoarthritis mediate pain relief and improve function by unloading the joint (increasing the joint separation) remains inconclusive. When knees with medial compartment osteoarthritis are braced, neutral alignment performs as well as or better than valgus alignment in reducing pain, disability, muscle cocontraction, and knee adduction excursions. Pain relief may result from diminished muscle cocontractions rather than from so-called medial compartment unloading. (Ramsey, 2007) (Chew, 2007) The results of this systematic review suggest that knee braces and foot orthoses are effective in decreasing pain, joint stiffness, and drug dosage, and they also improve proprioception, balance, Kellgren/Lawrence grading, and physical function scores in subjects with varus and valgus knee osteoarthritis. They should be cautiously considered as conservative management for relief of pain and stiffness and improving physical function for persons with knee osteoarthritis. (Raja, 2011) The knee adduction moment has an integral role in the development and progression of knee OA. A number of conservative biomechanics-based interventions can reduce the knee adduction moment effectively via different mechanisms. Many of these conservative biomechanical strategies could be employed in early stage OA and might help to prevent and/or delay disease progression. Valgus knee braces secured around the thigh and lower leg and worn throughout the day are a conservative treatment strategy for patients with medial knee OA. The underlying rationale for use of a valgus knee brace is the application of a valgus moment (knee abduction moment) to the knee joint, which could reduce the knee adduction moment during walking and unload the medial compartment of the knee. Valgus knee braces reduce the net knee adduction moment during walking in healthy young adults and in patients with medial knee OA. Pain is a symptom of knee joint OA, and a valgus knee brace substantially reduces pain immediately upon use, and after continuous wear for durations ranging between 2 weeks and 12 months. Improvements in function have also been reported in patients with OA following valgus

knee bracing for durations of between 6 months and 12 months. Although valgus bracing achieves effective unloading of the medial compartment of the knee and offers potential for improving the clinical outcome in patients with knee OA, the success of this intervention relies upon the patient being prepared to wear the knee brace continually. Valgus knee braces are bulky, potentially uncomfortable and might not be a practical daily solution for many patients. (Reeves, 2011) Knee bracing after ACL reconstruction appears to be largely useless, according to a systematic review. Postoperative bracing did not protect against reinjury, decrease pain, or improve stability. (Kruse, 2012) There is no clear and recent documentation of knee instability or ligament damage avascular necrosis or any other indication for knee brace. Therefore, the request is not medically necessary.

Post-op physical therapy; amount and frequency/duration not specified: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) There is no documentation on the frequency/duration of the post-op physical therapy sessions. The frequency of the treatment should not exceed 3 sessions. More sessions will be considered when functional and objective improvement are documented. In addition, there is no documentation that the patient cannot perform home exercise. Therefore, the request for Post-op physical therapy is not medically necessary.