

Case Number:	CM13-0050780		
Date Assigned:	01/15/2014	Date of Injury:	12/08/2012
Decision Date:	03/04/2015	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	11/14/2013

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:

This 28 year old female was injured 12/8/12 resulting right knee pain with pain intensity of 7/10 initially. The mechanism of injury was not indicated. On 5/19/13 she underwent arthroscopy of the right knee with partial anterior horn medial meniscectomy; complete synovectomy of the knee; surface chondroplasty of the medial femoral condyle and arthrocentesis and injection of 0.5% plain Marcaine. By 7/23/13 she had completed 12 post-operative physical therapy sessions. Additional physical therapy was requested but not certified. Range of motion of the right knee is decreased. She exhibited residual quadriceps weakness and residual osteochondral defect of the medial femoral condyle. Her medications included Tramadol. There was no mention of activities of daily living or functional capacity. She had significant pain (4/10) with stairs and with squatting and kneeling. She can return to work with restrictions of no kneeling, squatting or climbing (10/15/13). Physical examination of the right knee revealed swelling, 120 flexion, limited range of motion, tenderness on palpation and negative all special tests, normal sensation and 4/5 strength.

IMR ISSUES, DECISIONS AND RATIONALES

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

WORK CONDITIONING 12 VISITS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 125-126.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) Work conditioning, wo.

Decision rationale: Per the CA MTUS guidelines cited below, criteria for work conditioning includes:(1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA). (2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning. (5) A defined return to work goal agreed to by the employer & employee: (9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities. A recent detailed clinical evaluation note of the treating physician was not specified in the records. A work-related musculoskeletal deficit that precludes the ability to safely achieve current job demands was not specified in the records provided. The medical records submitted did not provide documentation regarding a specific defined return-to-work goal or job plan that has been established, communicated and documented. There was no documentation provided for review that the patient failed a return to work program with modification. A recent FCE documenting physical demands level was not specified in the records provided. Per the records provided, the patient has received 12 post op PT visits for this injury. There are no complete therapy progress reports that objectively document the clinical and functional response of the patient from the previously rendered sessions. As cited below, there should be an evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Any such type of evidence is not specified in the records provided. Previous PT visit notes are not specified in the records provided. The medical necessity of the request for WORK CONDITIONING 12 VISITS is not fully established in this patient.