

Case Number:	CM15-0121431		
Date Assigned:	07/02/2015	Date of Injury:	09/11/2012
Decision Date:	07/31/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	06/23/2015

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:

This 43 year old man sustained an industrial injury on 9/11/2012. The mechanism of injury is not detailed. Treatment has included oral medications and acupuncture. Physician notes dated 5/12/2015 show complaints of right knee pain. Recommendations include physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 physical therapy sessions for the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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)" The patient underwent at least 24 sessions of physical therapy without clear documentation of efficacy. There is no recent objective findings that support musculoskeletal dysfunction requiring additional physical therapy. There is no documentation that the patient cannot perform home exercise. Therefore, the request for 12 physical therapy sessions for the right knee is not medically necessary.

Knapp hinged brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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: According to ODG guidelines, Knee brace is "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. Criteria for the use of knee braces: Prefabricated knee braces may be appropriate in patients with one of the following conditions: 1. Knee instability; 2. Ligament insufficiency/deficiency; 3. Reconstructed ligament; 4. Articular defect repair; 5. Avascular necrosis; 6. Meniscal cartilage repair; 7. Painful failed total knee arthroplasty; 8. Painful high tibial osteotomy; 9. Painful unicompartmental osteoarthritis; 10. Tibial plateau fracture Custom-fabricated knee braces may be appropriate for patients with the following conditions which may preclude the use of a prefabricated model: 1. Abnormal limb contour, such as: a. Valgus [knock-kneed] limb; b. Varus [bow-legged] limb; c. Tibial varum; d. Disproportionate thigh and calf (e.g., large thigh and small calf); e. Minimal muscle mass on which to suspend a brace; 2. Skin changes, such as: a. Excessive redundant soft skin; b. Thin skin with risk of breakdown

(e.g., chronic steroid use); 3. Severe osteoarthritis (grade III or IV); 4. Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain); 5. Severe instability as noted on physical examination of knee. 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 for Knapp hinged brace is not medically necessary.