

Case Number:	CM15-0096373		
Date Assigned:	05/29/2015	Date of Injury:	10/02/2013
Decision Date:	07/02/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	05/15/2015

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 York
 Certification(s)/Specialty: Anesthesiology

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 37-year-old male, who sustained an industrial injury on 10/02/2013. Diagnoses include Plica syndrome and right lateral meniscus tear status post arthroscopic meniscectomy. Treatment to date has included surgical intervention, activity modification, diagnostics, 12 sessions of physical therapy and medications including Anaprox and Ultracet. Magnetic resonance angiography (MRA) of the right knee dated 5/07/2014 showed no acute ligamentous injury. Truncation of the body of the lateral meniscus likely from previous surgery. There is abnormal signal along its undersurface it such that fibrillation or recurrent tear not excluded. Medial meniscus is intact. Per the Primary Treating Physician's Progress Report dated 4/30/2015, the injured worker reported right knee pain. Physical examination of the right knee is not documented. Condition is improving per the medical notes. The plan of care included additional physical therapy and authorization was requested for 12 postoperative physical therapy visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Manual therapy techniques, three times weekly for the right knee, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 7, and 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chiropractic Manipulation.

Decision rationale: According to MTUS, Manual Therapy or Chiropractic therapy is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Per the MTUS, chronic pain section citation listed above, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks, with any further manual therapy contingent upon functional improvement. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, the requested number of sessions exceeded the MTUS recommendation. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Therapeutic exercises, three times weekly for the right knee, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 7 and 98-99.

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

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. 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. 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 assisting devices. In this case, the patient completed a total of 12 physical therapy sessions post-operatively and received physical therapy prior to surgery. There is no documentation indicating that the patient had a defined functional improvement in his condition. There is no specific indication for the requested additional PT sessions. Medical necessity for the requested item has not been established. The requested PT is not medically necessary.

Ultrasound three times weekly for the right knee, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 7 and 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Therapeutic Ultrasound.

Decision rationale: According to the ODG, therapeutic ultrasound treatment is not recommended over other simpler heat therapies. Therapeutic ultrasound is one of several rehabilitation interventions used for the management of pain due to patello-femoral pain syndrome. Medical necessity for the requested item has not been established for this patient. The requested treatment is not medically necessary.

Mechanical traction, three times weekly for the right knee, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 7 and 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Traction, knee (skeletal traction treatment).

Decision rationale: According to the ODG, skeletal traction treatment for the knee is not generally recommended. Skeletal traction treatment is reserved for patients for whom surgery is contraindicated. For tibial plateau fractures, skeletal traction and early knee movement may be a valid alternative to surgery, but should probably be reserved for cases where operation is undesirable. Traction is used to manage fractures in an effort to realign broken bones; it is most often used as a temporary measure when operative fixation is not available for a period of time. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Dynamic activities, three times a week for the right knee, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 7 and 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Static Progressive Stretch (SPS) Therapy.

Decision rationale: According to the ODG, static progressive stretch (SPS) therapy uses mechanical devices for joint stiffness and contracture to be worn across a stiff or contracted joint and provide incremented tension in order to increase range of motion. Dynamic splinting devices for the knee, elbow, wrist or finger are recommended as an adjunct to physical therapy with documented signs of significant motion stiffness/loss in the sub-acute injury or post-operative period (i.e., at least 3 weeks after injury or surgery), or in the acute post-operative period with a prior documented history of motion stiffness/loss in a joint, along with additional surgery done to improve motion to that joint. There is no documentation of significant motion stiffness to warrant the requested therapy. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Electrical stimulation, three times a week for the right knee, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 7 and 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Electrical Stimulation.

Decision rationale: According to the ODG, the AHRQ Comparative Effectiveness Review of PT for knee arthritis concluded that electrical stimulation improved global assessment, but worsened pain, and did not improve disability, health perception, and gait, joint, transfer, and composite function measures. There is no specific indication for the requested electrical stimulation. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Hot or cold packs three times a week for the right knee, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 7 and 98-99.

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

Decision rationale: According to the CA MTUS/ACOEM Guidelines, the home application of hot and cold packs is just as effective as those performed by a therapist. If hot/cold therapy is desired, hot and cold packs are readily available. There is no specific indication for application of hot/cold packs by a therapist. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Self care management training three times a week for the right knee, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 7 and 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine 2014.

Decision rationale: Treatment of knee conditions should include approaches to support self-care and exercise based interventions. The most specific way to combine self-care and exercise has however, not been determined sufficiently. Per the reviewed literature potentially the most beneficial components of self-care management involves training self-management skills, information delivery, and goal setting. There is no documentation of medical necessity for the requested self-care management training sessions. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Neuromuscular reeducation three times a week for the right knee, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 7 and 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine 2014.

Decision rationale: Neuromuscular re-education involves the use of therapeutic techniques for the purpose of improving impaired movement, balance, coordination, decreased kinetic sense, and impaired proprioception. The documentation indicates the patient has undergone physical therapy with the establishment of a home exercise program. There is no specific indication for the requested neuromuscular re-education sessions. Medical necessity for the requested sessions has not been established. The requested sessions are not medically necessary.