

Case Number:	CM15-0099659		
Date Assigned:	06/02/2015	Date of Injury:	03/15/2012
Decision Date:	06/30/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	05/22/2015

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, New York
 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:

The injured worker is a 54-year-old female, with a reported date of injury of 03/15/2012. The diagnoses include lumbar spine musculoligamentous strain/sprain with radiculitis, rule out lumbar spine discogenic disease; rule out left knee internal derangement; and status post left knee surgery with residuals. Treatments to date have included left knee surgery on 06/20/2013; an MRI of the left knee on 03/05/2015 which showed osteoarthritis, most severe in the medial compartment, small effusion, subcortical cyst in the lateral tibial plateau, and misshapen mid medial meniscus; and a cane. The progress report dated 04/22/2015 indicates that the injured worker complained of pain in the lower back and left knee. She rated her low back pain 6 out of 10, which had remained the same since her last visit; and rated her left knee pain 8 out of 10, which had increased from 7 out of 10 on the last visit. The objective findings include tenderness to palpation over the paraspinal muscles in the lumbar spine, restricted lumbar spine range of motion, positive bilateral straight leg raise, left greater than right, tenderness to palpation of the left knee, restricted range of motion of the left knee, and positive McMurray's test. The treating physician requested aquatic therapy for the left knee and a power uplift seat.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic Therapy for the left knee 2 times a week for 6 weeks power uplift seat: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

Decision rationale: The request is considered not medically necessary. Aquatic therapy is recommended as an optional form of exercise therapy as an alternative to land-based physical therapy when reduced weight bearing is desirable. There is no documentation that the patient required an alternative to land-based therapy. There is no documentation that the patient had failed land-based therapy. She had sessions of aquatic therapy but there was no documentation of improvement in pain and functional capacity. Therefore, aquatic therapy is not medically necessary at this time.

Power uplift seat: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and leg-durable medical equipment (DME).

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

Decision rationale: The request is considered not medically necessary. ODG guidelines were used as MTUS does not address the use of a power uplift seat. As per ODG, durable medical equipment is indicated if it is primarily used for a medical purpose. There was no documentation that the patient was unable to rise from a seated position without the use of this equipment. There was no specified purpose for this equipment. Therefore, the request is considered not medically necessary.