MAXIMUS Federal Services

| Case Number: | CM13-0017617 | | |
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| Date Assigned: | 11/06/2013 | Date of Injury: | 03/23/2010 |
| Decision Date: | 01/10/2014 | UR Denial Date: | 08/15/2013 |
| Priority: | Standard | Application Received: | 08/28/2013 |

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in physical medicine and rehabilitation, and is licensed to practice in California. 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 physician 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/services.

## 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 patient is a 39-year-old with a date of injury on 3/25/10 who has the following issues: s/p right knee arthroscopy for subchondral cyst and subchondral sclerosis; thoracic and lumbar pain with normal EMG/NCS (electromyography/nerve conduction velocity test); bilateral groin pain and left knee pain. The patient has had chiropractic treatment and was given Naprosyn, Prilosec, Norco, and Flexeril, and topical cream. On 8/28/12 patient was determined to be "near MMI". Subjectively, the patient has pain 9/10 sharp, constant, worse with movement. PE: Positive Kemps, positive spasm, tenderness in the paraspinals, and reduced ROM (range of motion), positive milgram test, + SLR, + Mcmurray, limited ROM knee, tenderness in med/lat left knee. No swelling.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**One lumbar rehabilitation kit:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines Physical Medicine, 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. This patient had received chiropractic treatment and was near MMI in August 2012. Patient still has residual pain of 9/10 in the back and knee. It is reasonable for him to be transition to home exercise program. As such a lumbar kit which includes 2 resistance bands, body ball, compression wrap, pump, exercise mat, and instructional manual would be helpful toward this goal. I feel that the request fits in the interpretation of the guidelines. The request for one lumbar rehabilitation kit is medically necessary and appropriate.

**One interferential unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

**Decision rationale:** The Physician Reviewer's decision rationale: According to the Chronic Pain Medical Treatment Guidelines Interferential Current Stimulation, it is "not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. While not recommended as an isolated intervention, the patient selection criteria if Interferential stimulation is to be used anyway, and is possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: - Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or - Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person." Even if the indication is stretched as provided in the guidelines above, ICS should be only for a one month trial with documentation of functional improvement. The request for one interferential unit is not medically necessary or appropriate.

**Ten electrical stimulator supplies, 2 lead, per:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Ten replacement batteries:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**One set up and delivery charge:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.