

Case Number:	CM13-0035945		
Date Assigned:	12/13/2013	Date of Injury:	09/01/2000
Decision Date:	03/31/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/18/2013

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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 40-year-old female who reported an injury on 09/01/2000. The mechanism of injury was not provided for review. The patient's most recent clinical documentation indicated that the patient was status post right knee surgery in 2007 and 04/2013. It was noted that the patient had persistent severe aching low back pain rated 7/10 that radiated into the right lower extremity and right knee pain described as 6/10. It was noted that the patient was not participating in any type of therapy and pain was managed with cyclobenzaprine and tramadol. Physical findings included tenderness to palpation and spasming of the paralumbar musculature with a positive sciatic stretch sign and a negative straight leg raising test. Examination of the right knee revealed a positive McMurray's test with medial joint line tenderness and limited range of motion described as 120 degrees in extension with positive patellar grinding and infrapatellar tenderness. The patient's diagnoses included internal derangement of the right knee, patella chondromalacia of the right knee, lateral tracking patella, lumbar sprain/strain, and lumbar discopathy/facet arthropathy. The patient's treatment plan included an MRI of the lumbar spine, an MRI of the right knee, aquatic therapy, and a Pro-stim unit for home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic therapy for the right knee (8 sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy, Physical Medicine Page(s): 22, 98-99.

Decision rationale: The requested aquatic therapy for the right knee is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends aquatic therapy for patients who require a nonweightbearing environment while participating in active therapy. Although the patient does have persistent pain complaints and range of motion deficits that would benefit from active therapy, there is no support that the patient requires a nonweightbearing environment. Therefore, the need for aquatic therapy is not clearly established. As such, the requested aquatic therapy for the right knee is not medically necessary or appropriate.

MRI of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 341-343.

Decision rationale: The requested MRI of the right knee is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends and MRI of the knee to determine ligamentous damage or in the presence of red flag conditions. The clinical documentation submitted for review does not clearly provide any evidence that the patient has ligament injury that would benefit from an additional diagnostic study. Additionally, there is no documentation that the patient has any red flag conditions that would support the need for an imaging study. As such, the requested MRI of the right knee is not medically necessary or appropriate.

MRI lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The requested MRI of the lumbar spine is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends imaging studies for patients who have progressive neurological deficits. The clinical documentation submitted for review does not provide any evidence of neurological deficits to support the patient's subjective complaint of radiating pain. Therefore, the need for an MRI of the lumbar spine is not clearly established. As such, the requested MRI of the lumbar spine is not medically necessary or appropriate.

Pro-stim 5.0 unit for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy. Page(s): 114-122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 114-122.

Decision rationale: The requested Pro-stim 5.0 unit for the lumbar spine is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of transcutaneous electrotherapy for patients with intractable, chronic pain that have failed to respond to other first line treatments. This type of therapy is also recommended as an adjunct therapy to a functional restoration program. The clinical documentation submitted for review does not provide any evidence that the patient is currently participating in an active therapy program. Additionally, the requested unit is a multi current unit. The California Medical Treatment Utilization Schedule recommends interferential current stimulation for patients who have failed to respond to a TENS unit and other types of first line treatments. California Medical Treatment Utilization Schedule does not support the use of neuromuscular electrical stimulation as this type of therapy is primarily used in the rehabilitation of stroke patients. Additionally, California Medical Treatment Utilization Schedule does not recommend galvanic stimulation as it is highly investigational and not supported by scientific evidence. As the requested unit components that are not supported by guideline recommendations, the Pro-stim 5.0 unit for the lumbar spine is not indicated. Additionally, the request as it is written does not clearly identify if this is for rental or for purchase. As such, the requested Pro-stim 5.0 unit for the lumbar spine is not medically necessary or appropriate.