

Case Number:	CM13-0067438		
Date Assigned:	01/03/2014	Date of Injury:	03/06/2012
Decision Date:	05/22/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/17/2013

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. The expert reviewer is Board Certified in Occupational Medicine 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 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/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 has filed a claim for sprain/strain of the knee and leg associated with an industrial injury date of March 5, 2012. A utilization review from December 3, 2013 denied the requests for: physical therapy due to no documentation of response to previous physical therapy, home exercise program, hand therapy due to no documented response to a previous injections to necessitate physical therapy, and transcutaneous electrical nerve stimulation (TENS) unit due to no objective measures of pain relief and functional gains. The treatment to date has included oral pain medications, home exercise program, physical therapy times six, right knee injection, TENS unit, and bilateral knee surgery. Medical records from 2013 were reviewed showing the patient complaining of bilateral knee pain made worse by activity such as climbing stairs. Medications are noted to be working well with no side effects. The patient's functionality is stable. On examination, the right knee had restricted range of motion. Movements are painful with flexion beyond 100 degrees. There was tenderness over the medial joint line and 1+ effusion for the right knee. Orthopedic tests were negative. The left knee was noted to be tender over the medial joint line with one plus effusion. The patient has never had physical therapy for the hands. The wrist pain prevents the patient from performing certain work functions. Electrodiagnostic studies from July 2013 demonstrated mild right carpal tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 SESSIONS RIGHT KNEE PT: Upheld

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

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

Decision rationale: As stated in the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that treatment regimens should be tapered and transitioned into a self-directed home program. In this case, the patient has had previous physical therapy. However, the documentation did not indicate functional gains derived from the previous physical therapy sessions such as improved ability to perform activities of daily living or improve work functions. In addition, the patient has a home exercise program. There is no discussion why the home exercise program cannot suffice. Therefore, the request for physical therapy for the right knee is not medically necessary.

6 SESSIONS HAND THERAPY: Upheld

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

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

Decision rationale: As stated in the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that treatment regimens should be tapered and transitioned into a self-directed home program. In this case, the patient was noted to have not received physical therapy for the carpal tunnel syndrome. The patient has had electrodiagnostic studies confirming mild carpal tunnel syndrome in July 2013. However, the request does not specify the laterality of the hand therapy. Given a nonspecific request, the request for 6 sessions hand therapy is not medically necessary.

EXTENSION OF AUTHORIZATION FOR RIGHT KNEE TENS MACHINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

Decision rationale: As stated in the California MTUS Chronic Pain Medical Treatment Guidelines, transcutaneous electrical nerve stimulation (TENS) units are not recommended as the primary treatment modality, but are recommended as an adjunct. Objective measures of functional gains such as improved ability to perform activities of daily living and improvement in analgesia such as decreased medication use should be documented for continued use. In this case, the patient has been using a TENS unit. However, the documentation does not provide any evidence of functional gains with regards to activities of daily living and pain control in terms of

decreased medication usage. Therefore, the request for extension of authorization for right knee TENS machine is not medically necessary.