

<b>Case Number:</b>	CM14-0053819		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	04/01/2010
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	04/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate this 72-year-old female was reportedly injured on 4/1/2010. The mechanism of injury was noted as a slip and fall and landed on the right knee. The injured worker underwent a right total knee arthroplasty on 3/28/2013. The previous utilization review referenced a progress note dated 1/30/2014 but that progress note is not provided for this independent medical review. The reviewer indicated that the progress note documented ongoing complaints of right knee pain which worsened with activity and weight-bearing. Physical examination of the right knee showed healed surgical wounds and range of motion 10 to 84. Ligaments were stable. Good muscle bulk. Neurovascular is intact to the right leg. Diagnoses: Right knee osteoarthritis/arthrofibrosis and possible right leg reflex sympathetic dystrophy. Previous treatment included physical therapy, right knee surgery, and medications to include Voltaren gel, Soma, Norco and Fioricet. A request was made for Flex IT Unit Purchase and was not certified in the utilization review on 4/4/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flex IT unit purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113-116.

**Decision rationale:** MTUS treatment guidelines recommend against using transcutaneous electrical nerve stimulation as a primary treatment modality and indicate that a one-month trial must be documented prior to purchase of any units. Review of the available medical records failed to document a one-month trial. MTUS guidelines require that a trial include documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Given the lack of clinical documentation, this request is not considered medically necessary.