

Case Number:	CM14-0066024		
Date Assigned:	08/08/2014	Date of Injury:	12/28/2006
Decision Date:	10/31/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	05/09/2014

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 & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in Texas. 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 injured worker is a 58 year old male who reported an injury to his right knee and right foot on 12/28/2006. The injured worker stated the initial injury occurred when he was separating two machines resulting in twisted knee. A clinical note dated 02/19/14 indicated the injured worker complaining of tenderness and swelling along the medial and lateral joint lines of the right knee. The injured worker had positive McMurray test. Laxity was +1 at the ACL. Upon exam, the injured worker demonstrated -5-100 degrees of range of motion at the right knee. Strength was 4/5 in both flexion/extension. Tenderness was identified at the arch and medial region of the right foot. Strength was 4/5 at both plantar and dorsiflexion. The injured worker underwent an arthrotomy, lavage, debridement of the right knee, and lysis of adhesions on 11/19/13. A clinical note dated 03/19/14 indicated the injured worker continuing with range of motion strength deficits throughout the right knee and ankle. The injured worker was recommended for physical therapy and orthotic devices and continued use of TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3x4 to right knee: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Physical Medicine

Decision rationale: The request for physical therapy 3 x 4 for the right knee is not medically necessary. The injured worker previously underwent physical therapy at the right knee. However, no information was submitted regarding any objective functional improvement to include range of motion, strength and endurance through the course of treatment. Ongoing therapy would be indicated for improvements in any of these areas. Additionally, it is unclear as to the number of previously completed physical therapy sessions to date. Given this, the request is not indicated as medically necessary.

Physical Therapy 3x4 to right foot: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot Chapter, Physical Medicine

Decision rationale: The previous utilization review indicates the injured worker was approved for partial treatment for a short course of physical therapy addressing the right foot complaints. However, no information was submitted regarding any objective functional improvement through the treatment to include range of motion, strength and endurance. Additional therapy would be indicated for improvements in these areas. Without the necessary information in place supporting the injured worker's positive response to previously rendered therapy, it is unclear if the injured worker would benefit from additional therapy. Given this, the request is not indicated as medically necessary.

walking boot: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot Chapter, Orthotic

Decision rationale: The request for walking boot for right ankle is not medically necessary. The injured worker demonstrated limited subjective and objective findings at the right foot indicating a likely benefit of a walking boot. Strength deficits were identified at the right ankle to include findings of 4/5 with both the plantar and dorsiflexion. It would be reasonable to expect the injured worker to demonstrate significant strength, range of motion as well as endurance deficits as well as ambulatory difficulties as well as instability measured within the clinical setting to

confirm functional deficits. No information was submitted confirming the likely benefit from the use of a walking boot. Therefore, this request is not medically necessary.

Re positionable electrodes: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS), Page(s): 105-107.

Decision rationale: The request for Re-positional electrodes is not medically necessary. The injured worker previously utilized a TENS unit. However, no objective clinical data was submitted regarding a positive response to use of this treatment modality. No information was submitted regarding an objective functional improvement as well as a reduction in pain with the use of a TENS unit. Without this information, it is unclear if the injured worker would fully benefit from the continued use of a TENS unit. Therefore, the request is not indicated as medically necessary.

9 volt batteries: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107.

Decision rationale: The request for 9 volt batteries is not medically necessary. The injured worker previously utilized a TENS unit. However, no objective clinical data was submitted regarding a positive response. Without a set of objective findings confirming a positive response with the use of the TENS unit, the request is not indicated as medically necessary.

Bifurcated lead wires: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS), Page(s): 105-107.

Decision rationale: The request for bifurcated lead wires is not medically necessary. The injured worker previously utilized TENS unit. However, no objective clinical data was submitted regarding the positive response to use of this modality. Without confirmatory evidence in place, it is unclear if the continued use of a TENS unit would be beneficial. This would include range of motion improvements at the affected joints, strength and endurance

improvements at the affected musculature. Given this, the request is not indicated as medically necessary.

knee brace: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Bracing (immobilization)

Decision rationale: The request for right knee brace is medically necessary. There is an indication the injured worker has undergone physical therapy at the right knee. The injured worker is continuing with -5-100 degrees range of motion at the right knee with 4/5 strength with both flexion/extension as well as laxity at the ACL. Given these factors the use of a brace is indicated in order to provide the injured worker with an increase in stability. Therefore, the request is medically necessary.