

<b>Case Number:</b>	CM14-0212587		
<b>Date Assigned:</b>	12/30/2014	<b>Date of Injury:</b>	08/19/2014
<b>Decision Date:</b>	04/06/2015	<b>UR Denial Date:</b>	12/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2014

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

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 48-year-old female who reported an injury on 08/19/2014. The mechanism of injury involved repetitive activity. The current diagnoses include left hip strain, left knee sprain, rule out left knee internal derangement, and rule out left knee meniscal tear. The only clinical documentation submitted for review is a Doctor's First Report of Occupational Injury or Illness dated 11/19/2014. The injured worker presented with complaints of low back pain, left hip pain, and left knee pain. Upon examination, there was tenderness to palpation over the posterior left hip/thigh, decreased range of motion, positive Patrick test, left knee swelling, tenderness of the anterior and posterior left knee, lateral and medial joint line tenderness, patellofemoral joint tenderness, decreased range of motion, patellofemoral grinding, positive McMurray's sign, decreased deep tendon reflexes at the bilateral knees and ankles, diminished motor strength in the left lower extremity, and decreased sensation in the left lower extremity. Recommendations at that time included physical therapy once per week for 6 weeks. A prescription was issued for a left knee brace, an interferential unit, and a hot and cold unit. A Request for Authorization form was submitted on 11/19/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 1x6 - left hip and knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-338.

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

**Decision rationale:** The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. In this case, it is unclear whether the injured worker has previously participated in physical therapy. There was no documentation of a significant functional limitation with regard to the left hip. Given the above, the request is not medically appropriate.

**Interferential unit - left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**Decision rationale:** The California MTUS Guidelines state that interferential current stimulation 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. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse or significant pain from postoperative conditions. In this case, there was no documentation of a failure to respond to first line conservative treatment, including active rehabilitation and TENS therapy. There was also no documentation of a successful 1 month trial prior to the request for a unit purchase. Given the above, the request is not medically appropriate.

**Hot and cold unit - left knee:** 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:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state patient's at home local applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. In this case, there was no mention of a contraindication to at home local applications of heat or cold as opposed to a motorized mechanical device. As the medical necessity has not been established, the request is not medically appropriate at this time.

