MAXIMUS Federal Services

Case Number:	CM14-0086517		
Date Assigned:	07/23/2014	Date of Injury:	03/22/2014
Decision Date:	04/10/2015	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	06/09/2014

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. 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, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 43-year-old man sustained an industrial injury on 3/22/2014 to multiple body parts as a result of cumulative injury. Current diagnoses include left costochondritis, abdominal supraumbilical hernia, lumbar spine sprain/strain, bilateral knee internal derangement, right foot sprain/strain, chronic headaches, opthamalogical complaints, and rule out sinus tarst syndrome. Treatment has included oral medications, Physician notes dated 4/7/2014 show complaints of bilateral arm pain, constant left sided chest pain, constant low back pain, constant bilateral knee pain, constant bilateral ankle pain, and right eye pain. Recommendations include outside medical records to forwarded to this physician, chiropractic treatment with physiotherapy, adbominal wall CT scan, chest x-ray, EMG/nerve conduction study of the bilateral lower extremities, consultations with neurology and opthamology, lumbar spine brace, left hinged knee brace, TENS /intereferential unit/multi-stim unti for home use, and continue with current medication management. On 5/12/2014, Utilization Review evaluated prescriptions for lumbosacral orthotic back support, bilateral functional hinged knee supports, and intraferential unit with electrodes, batteries, set up and delivery, that were submitted on 5/9/2014. The UR physician noted the following: regarding the back brace, there is no instability and has been no fusion. Regarding the knee supports, there is no instability and has been no surgery. Regarding the intraferential unit and supplies, there is no documentation of prior treatment, no trial to assess for objective response, no imaging, and no documentation of prior treatments. The MTUS, ACOEM Guidelines, (or ODG) was cited. The requests were denied and subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

LSO Back Support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Regarding the request for an LSO, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Within the documentation available for review, the patient is well beyond the acute stage of relief and there is no documentation of a pending/recent spine surgery, spinal instability, compression fracture, or another clear rationale for a brace in the management of this patient's chronic injury. In the absence of such documentation, the currently requested LSO is not medically necessary.

Bilateral Functional Hinged Knee Support: 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) Knee Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

Decision rationale: Regarding the request for a knee support, Occupational Medicine Practice Guidelines state that a brace can be used for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability although its benefits may be more emotional than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. Within the documentation available for review, there is no indication that the patient has any of the conditions noted above for which a knee brace is indicated. In the absence of such documentation, the currently requested knee support is not medically necessary.

IF Unit, Electrodes, Batteries, set up and delivery: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Stimulation device Page(s): 103.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: Regarding the request for an IF unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation outlined above. Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested IF unit is not medically necessary.