MAXIMUS Federal Services

Case Number:	CM15-0004748		
Date Assigned:	01/16/2015	Date of Injury:	08/19/2013
Decision Date:	03/23/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	01/09/2015

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: New York
Certification(s)/Specialty: Neurological Surgery

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 64 year old female linen sheets coordinator reported a cumulative trauma work related injury on August 19, 2013,due to working in the linen department at a hospital where she did constant bending, twisting of her back, continuous gripping, grasping, frequent bending of her neck, constant standing, kneeling, bending, and pushing. She experienced increased pain and discomfort to her neck, shoulders, arms, knees, legs and hands secondary to repetitious duties. She underwent anterior cervical disectomies and fusions in 1997,2005 and 2007. Her cervical spine x-rays disclosed and anterior cervical discectomies and fusion C4-7. Diagnoses included cervical and lumbar sprain, radiculopathy, left knee meniscal tear and degenerative joint disease. Magnetic Resonance Imaging (MRI) of the right knee revealed degenerative arthritis and a complex tear of the medial meniscus and right knee joint effusion. X rays of the lumbar spine revealed narrowing and no fracture. Treatment included pain medications and physical therapy. Currently, the injured worker complains of constant neck pain, arm pain, legs and knees pain. At times she is physically limited in her activities. On December 9, 2014, Utilization Review non-certified physiotherapy 2-3 times a week for 6 weeks to the right knee, cervical and lumbar areas, lumbar spine brace, TENS unit, Ultrasound Guided Steroid Injection of the left knee and a left knee arthroscopic, noting the California MTUS Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Service: Physiotherapy 2-3 Times A Week for 6 Weeks to The Right Knee/Cervical/Lumbar: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee, neck and physical medicine chapters

Decision rationale: The ODG guidelines recommend physical medicine sessions for old bucket handle meniscal tears 9 visits over 8 weeks. The requested treatment associated surgical service of physiotherapy 2-3 times a week for 6 weeks does not comply with the guidelines. Thus the requested treatment is neither appropriate or medically necessary. The ODG guidelines for a cervical strain recommend 10 visits 8 weeks. The requested treatment: Associated Surgical Service: Physiotherapy 2-3 times a week for 6 weeks to the cervical does not comply with guidelines and is thus not medically necessary or appropriate.The ODG guidelines for physical therapy for a lumbar sprain is 10 visits over 8 weeks. The requested treatment: Associated Surgical Service: Physiotherapy 2-3 times a week for 6 weeks to the lumbar does not comply with the guidelines and thus is not medically necessary or appropriate.

Lumbar Spine Brace: 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 Physical therapy chapter-lumbar supports

Decision rationale: According to ODG guidelines lumbar supports are not recommended for prevention of back pain. The guidelines note there is strong consistent evidence lumbar supports are not effective in preventing back pain. Documentation does not furnish evidence as to why the guidelines should not be followed. Thus the requested treatment:Lumbar spine brace is not medically necessary or appropriate.

Associated Surgical Service: TENS Unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physical therapy chapter-electrostimulation

Decision rationale: Per the ODG guidelines transcutaneous electrical neuro stimulation (TENS) is not recommended as an isolated intervention in the treatment of pain. While a one month trial may be considered in the treatment of chronic low back pain, the recommendations are that it is

used in conjunction with an evidence based program of conservative care. Documentation does not provide evidence that this is under consideration for the worker. Thus this requested treatment: Asssociated surgical service: TENS unit is not medically necessary or appropriate.

Associated Surgical Service: Ultrasound Guided Steroid Injection Left Knee: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee Chapter-Corticosteroid injections

Decision rationale: ODG guidelines note that ultrasound guided steroid injection of the knee is generally unecessary. The documentation does not show evidence the criteria are met for the injection, namely that the pain has not been controlled with medication or that the worker has been unable to function. Moreover, the sedimentaton rate should be is less than 40 and that there is no palpable warmth over the synovium. Thus the requested treatment: associated surgical service: Ultrasound guided steroid injection left knee is not medically necessary or appropriate.

Left Knee Arthroscopy: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee chapter-Diagnosatic arthroscopy

Decision rationale: ODG guidelines note that in patients with osteoarthritis arthroscopy for precise grading of the cartilage is limited. It is recommended if physical therapy or medications have failed and pain and functional limitations continue despite conservative care and the imaging findings are inconclusive. Documentation in this worker does not show that these criteria have been met. Thus this requested treatment:Knee arthroscopy is not medically necessary or appropriate.