MAXIMUS Federal Services

Case Number:	CM15-0104369		
Date Assigned:	06/08/2015	Date of Injury:	07/16/2013
Decision Date:	07/09/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	06/01/2015

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: 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 30 year old male, who sustained an industrial injury on 07/16/2013. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having right knee sprain/strain with internal derangement status post-surgery, right ankle sprain/strain, rule out right peroneal tenosynovitis, right foot sprain/strain, and left knee internal derangement as a compensable consequence due to favoring limping. Treatment and diagnostic studies to date has included physical therapy, laboratory studies, magnetic resonance imaging of the left knee, right knee injection, acupuncture, home exercise program, and medication regimen. In a progress note dated 04/30/2015 the treating physician reports complaints of constant right knee pain at the suprapatellar region and frequent left knee pain. The injured worker also has moderate to severe quadricep atrophy. The pain to the right knee is rated a 6 to 7 out of 10 and the pain to the left knee is rated an 8 out of 10. The injured worker's functional status is noted to be slower than expected. The progress note did not include a current medication regimen but did note a prescription for Flurbiprofen/Capsaicin/Camphor/Menthol Cream and Norco. The treating physician requested a Kneehab XP for the right knee due to disuse atrophy of the quadriceps resulting from injury. The treating physician also requested a urine drug screen, but the documentation provided did not contain the specific reason for the request of this laboratory study.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 KneeHab XP for the right knee: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of a transcutaneous Electrotherapy Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. There is no documented short-term or long-term goals of treatment with the Stim unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the Stim Unit without specified rental or purchase request or previous failed TENS trial. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the physical therapy treatment already rendered. The 1 KneeHab XP for the right knee is not medically necessary and appropriate.

1 Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urinalysis (opiate screening).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing, page 43.

Decision rationale: Per MTUS Guidelines, urine drug screening is recommended as an option before a therapeutic trial of opioids and for on-going management to differentiate issues of abuse, addiction, misuse, or poor pain control; none of which apply to this patient who has been prescribed long-term opioid this chronic injury. Presented medical reports from the provider have unchanged chronic severe pain symptoms with unchanged clinical findings of restricted range and tenderness without acute new deficits or red-flag condition changes. Treatment plan remains unchanged with continued medication refills without change in dosing or prescription for chronic pain. There is no report of aberrant behaviors, illicit drug use, and report of acute injury or change in clinical findings or risk factors to support frequent UDS. Documented abuse, misuse, poor pain control, history of unexpected positive results for a non-prescribed scheduled drug or illicit drug or history of negative results for prescribed medications may warrant UDS and place the patient in a higher risk level; however, none are provided. The 1 Urine drug screen is not medically necessary and appropriate.