MAXIMUS Federal Services

Case Number:	CM15-0182508		
Date Assigned:	09/23/2015	Date of Injury:	07/10/2012
Decision Date:	10/28/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/16/2015

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:

This is a 32 year old male with a date of injury of July 10, 2012. A review of the medical records indicates that the injured worker is undergoing treatment for history of lumbar musculoligamentous sprain and strain with bilateral lower extremity radiculopathy, right wrist sprain, and right hip sprain. Medical records dated August 20, 2015 indicate that the injured worker complains of right knee pain, lower back pain, right hip pain, and right wrist and forearm pain. Records also indicate that the treating physician stated that injured worker reported "Prior to the incident, he was able to do more activities of daily living including squatting, riding, standing, walking, stooping, pushing and pulling, which he can no longer do". Per the treating physician, the employee has not returned to work. The physical exam dated August 20, 2015 reveals a decreased lumbar lordotic curvature, tenderness to palpation with muscle guarding over the bilateral lumbar paraspinal muscles, tenderness to palpation over the lumbosacral junction, decreased range of motion of the lumbar spine (flexion of 46 degrees, extension of 16 degrees, right side bending of 19 degrees, left side bending of 20 degrees), tenderness to palpation over the dorsal capsule of the right wrist, tenderness to palpation over the right anterior hip joint and greater trochanter, positive Patrick Fabere's test on the right, minimal diffuse swelling of the right knee, tenderness to palpation over the right medial joint line, lateral joint line, and patellar region, patellofemoral crepitus on the right, 1+ laxity with Lachman's test, 2+ laxity with Anterior drawer test, pain with McMurray's test, decreased sensation to pinprick and light touch along the L4 distributions bilaterally, and ambulating with a limp. Treatment has included x-rays of the lumbar spine that showed normal findings, x-ray of the right wrist that showed normal

findings, medications (Motrin 800mg for an unspecified time), right knee corticosteroid injection, right knee arthroscopy on November 26, 2012, and twelve sessions of postoperative physical therapy. The utilization review (September 14, 2015) non-certified a request for indefinite use of an interferential unit and six sessions of physical therapy for the right knee. On September 28, the utilization review partially certified the request for two sessions of physical therapy for the right knee (original request for six sessions).

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy right knee, 6 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Review indicates the request for PT was modified. Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. Therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. Submitted reports have no acute flare-up or specific physical limitations to support for physical/occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The Physical therapy right knee, 6 sessions is not medically necessary or appropriate.

Interferential unit indefinite use: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment

modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved functional status derived from any transcutaneous electrotherapy to warrant a purchase of an interferential unit for indefinite home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process with improved work status and exercises not demonstrated here. The Interferential unit indefinite use is not medically necessary or appropriate.