

Case Number:	CM15-0185941		
Date Assigned:	09/28/2015	Date of Injury:	05/07/2015
Decision Date:	11/03/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/21/2015

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: Preventive Medicine, Occupational Medicine

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 33-year-old female with a date of industrial injury 5-7-2015. The medical records indicated the injured worker (IW) was treated for knee sprain and strain. In the 7-20-15 Doctor's First Report notes, the IW reported constant right knee pain rated 4 to 5 out of 10 and up to 8 out of 10, which was similar to her report of 5 out of 10 pain at her 7-2-15 visit. She stated the pain increased with prolonged walking. Objective findings on 7-20-15 included tenderness at the pes anserinus insertion more than the medial knee. Valgus, varus, drawer's and Lachman's tests were negative. Right knee flexion was decreased 20% with moderate pain in the medial knee; extension was within normal limits with slight to moderate medial knee pain. The IW was allowed light duty work. Treatments included medications (Voltaren gel, Norco and Ultram), heat and cold application and manual therapy to the right knee. A Request for Authorization dated 7-27-15 was received for electrical muscle stimulation once a week for six weeks. The Utilization Review on 8-25-15 non-certified the request for electrical muscle stimulation once a week for six weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrical muscle stimulation 1 time a week for 6 weeks: 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: MTUS Guidelines are very specific with the recommendation that muscle stimulation is not recommended for chronic musculoskeletal conditions and is only recommended for post stroke rehabilitation. This individual does not meet this criteria and there are no unusual circumstances such as prolonged immobilization that might justify an exception to the Guideline recommendations. The Electrical muscle stimulation 1 time a week for 6 weeks is not supported by Guidelines and is not medically necessary.