

Case Number:	CM15-0192759		
Date Assigned:	10/06/2015	Date of Injury:	02/23/2001
Decision Date:	11/19/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	09/30/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 76 year old female patient who sustained an industrial injury on 2-23-2001. Diagnoses include lumbar spine sprain-strain, degenerative disc disease, rule out lumbar herniated disc, status post right knee surgery, left knee degenerative joint disease status post surgery. Per the physician notes dated 8-19-2015 she had complaints of lumbar spine and bilateral knee pain as well as numbness, tingling, and sleeping difficulties. The physical examination revealed lumbar spine range of motion flexion 40 degrees, extension 20 degrees, bending 30 degrees, positive straight leg raises bilaterally at 70 degrees displaying pain in the L5 and S1 dermatomes, weakness in the big toe dorsiflexor and big toe plantar flexor, Facet joint tenderness in L3, L4, and L5; Bilateral knee range of motion 0-120 degrees on the right and 0-115 degrees on the left, genu valgum 4 degrees, medial and lateral joint line tenderness and instability of the medial and lateral collateral ligaments and a positive chondromalacia patella test. The medications list includes Norco, ultram, zanaflex, gabapentin and topical creams. She has undergone right total knee arthroplasty in 2000; hysterectomy in 1979 and left knee arthroscopic surgery. She has had X-rays lumbar spine on 7/22/15; X-rays right knee on 7/22/15; X-rays of left knee on 7/22/15 which revealed degenerative joint disease with joint narrowing. Other therapy done for this injury was not specified in the records provided. Recommendations include MRI arthrogram of the left knee, right knee CT scan, interferential unit for home use, Norco, topical creams, and follow up in six weeks. Utilization Review dated 8/6/15 has approved -MRI lumbar spine, MRI of the left knee and CT scan of the right knee. Utilization Review denied requests for an interferential unit for home use and MRI arthrogram of the left knee on 9-24-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential unit for home use for 60 days: Upheld

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

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

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) is "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." Per the cited guideline "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)." Failure of conservative measures like physical therapy or pharmacotherapy for this patient is not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse is not specified in the records provided. The request for Interferential unit for home use for 60 days is not medically necessary or fully established for this patient at this juncture.

MRI Arthrogram, left knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, MR Arthrography.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Knee & Leg (updated 07/10/15) MR arthrography.

Decision rationale: Per the cited guidelines regarding knee MR arthrography "recommended as a postoperative option to help diagnose a suspected residual or recurrent tear, for meniscal repair or for meniscal resection of more than 25%. In this study, for all patients who underwent meniscal repair, MR arthrography was required to diagnose a residual or recurrent tear. In patients with meniscal resection of more than 25% who did not have severe degenerative arthrosis, avascular necrosis, chondral injuries, native joint fluid that extends into a meniscus, or a tear in a new area, MR arthrography was useful in the diagnosis of residual or recurrent tear.

Patients with less than 25% meniscal resection did not need MR arthrography. (Magee, 2003)"
Indications for knee MR Arthrography listed above are not specified in the records provided.
Per the utilization review dated 8/6/15 MRI of the left knee has been approved. This MRI
report is not specified in the records provided. Evidence of a recent meniscal repair is not
specified in the records provided. Response to recent conservative therapy is not specified in
the records provided. The request for an MRI Arthrogram, left knee is not medically necessary
or fully established for this patient.