

<b>Case Number:</b>	CM15-0194731		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	10/12/2010
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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 66 year old female patient with a date of injury on 10-12-10. The diagnoses include right knee osteoarthritis and status post left total knee revision surgery. Per the progress report dated 9-17-15 she is progressing well with rehabilitation of her left knee following left total knee revision. Her muscles continue to need reprogramming to maintain extension to her left knee. She ambulates with a walker and uses Norco for pain. She states her knee continues with weakness and fatigue. She has trouble maintaining extension of the knee when out of the immobilizer. She is doing her home exercise program and getting electrical stimulation in the left quad region while she is not exercising. Objective findings revealed knee flexion contracture, left knee swelling, reflexes normal, range of motion testing limited due to pain, 4 to 4-5 strength in the right lower extremity. The medications list includes norco, senna, lipitor and colace. She has undergone left total knee revision surgery on 12/3/2013. Treatments include: medication, physical therapy, home exercise program and surgery. On 2/3/15, peer review certified for 2 weeks of post op rehab and 12 physical therapy visits. Request for authorization dated 9-22-15 was made for knee hab machine and physical therapy 3 times per week for 4 weeks, 12 sessions. Utilization review dated 9-28-15 non-certified the requests.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Knee-hab machine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg - Neuromuscular electrical stimulation (NMES devices).

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

**Decision rationale:** Q-- Knee-hab machine. Knee hab is an Electrical Muscle Stimulation (EMS) device. Per the CA MTUS Chronic Pain Medical Treatment Guidelines neuromuscular electrical stimulation (NMES devices) is not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no trials suggesting benefit from NMES for chronic pain. Also used to stimulate quadriceps muscles following major knee surgeries to maintain and enhance strength during rehabilitation. (BlueCross BlueShield, 2005) (Aetna, 2005) Evidence of stroke is not specified in the records provided. Per the records provided the patient was getting electrical stimulation in the left quad region while she is not exercising. Response to prior use of electrical stimulation in terms of objective functional improvement is not specified in the records provided. She has undergone left total knee revision surgery on 12/3/2013. Evidence of recent knee surgery is not specified in the records provided. The medical necessity of Knee-hab machine is not medically necessary for this patient.

**Physical therapy, 3 times weekly for 4 weeks, 12 sessions:** Upheld

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

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

**Decision rationale:** Q-- Physical therapy, 3 times weekly for 4 weeks, 12 sessions. The cited guidelines recommend up to 9-10 physical therapy visits for this diagnosis. On 2/3/15, peer review certified 12 physical therapy visits. Therefore, the requested additional visits in addition to the previously rendered physical therapy sessions are more than recommended by the cited criteria. There is no evidence of significant progressive functional improvement from the previous physical therapy visits that is documented in the records provided. Per the cited guidelines, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of Physical therapy, 3 times weekly for 4 weeks, 12 sessions is not medically necessary for this patient at this time.

