MAXIMUS Federal Services

Case Number:	CM15-0196916		
Date Assigned:	10/12/2015	Date of Injury:	08/20/2013
Decision Date:	11/23/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	10/06/2015

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 38 year old, male who sustained a work related injury on 8-20-13. A review of the medical records shows he is being treated for left knee pain. Treatments have included left knee surgery on 10-10-14 and physical therapy. In the progress notes, the injured worker reports intense pain along the anterior portion of his left knee. He reports overall weakness and instability. He reports numbness and tingling down his left leg. In physical exam dated 9-8-15, he is noted to have quadriceps atrophy as well as overall weakness. Strength in left knee is 3+ out of 5. He has tenderness along the patellar tendon. He is working with restrictions. The treatment plan includes a recommendation for an EMG-NCV of lower extremities and for a muscle stimulation unit. The Request for Authorization dated 9-11-15 has a request for a muscle stimulation unit. In the Utilization Review dated 9-16-15, the requested treatment of the purchase of a muscle stimulation unit is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Muscle Stim Unit Purchase: Upheld

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

Orthop. 1999 Nov; (368): 166-75. Neuromuscular electrical stimulation after anterior cruciate ligament surgery; Official Disability Guidelines.

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

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 Muscle 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 Muscle Stim Unit 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 for purchase. The Muscle Stim Unit Purchase is not medically necessary and appropriate.