

Case Number:	CM15-0221853		
Date Assigned:	11/17/2015	Date of Injury:	02/04/2011
Decision Date:	12/31/2015	UR Denial Date:	10/27/2015
Priority:	Standard	Application Received:	11/11/2015

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, Hawaii
 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 49-year-old male, who sustained an industrial injury on 02-04-2011. He has reported injury to the right shoulder and bilateral knees. The diagnoses have included osteoarthritis lower limb; tear of medial cartilage of meniscus of knee; tear lateral meniscus of knee; adhesive capsulitis, shoulder; and bilateral shoulder internal derangement. Treatment to date has included medications, diagnostics, activity modification, physical therapy, and surgical intervention. Medications have included a topical compounded cream. A progress report from the treating physician, dated 06-12-2015, documented an evaluation with the injured worker. The injured worker reported pain in the right anterior knee, left anterior knee, right shin, right ankle, right foot, left shin, left ankle, left foot, left calf, left ankle, left foot, right calf, right ankle, right foot, right anterior shoulder, right anterior arm, upper thoracic, right cervical dorsal, right posterior shoulder, right mid thoracic, mid thoracic, right clavicular, right anterior wrist, left posterior knee, and right posterior knee; he rates his discomfort right now as a 7 out of 10 in intensity, and is noticeable approximately 100% of the time; the discomfort at its worst is rated as an 8 out of 10 in intensity, and at its best it is a 6 out of 10 in intensity; he reports numbness and tingling in the right calf, right ankle, left calf, left ankle, and right anterior wrist; notable anxiety and stress; insomnia; walking, sitting, and standing make his symptoms worse; and he feels better with pain medication. Objective findings included palpable tenderness at the lumbar, right sacroiliac, left sacroiliac, sacral, left and right buttock, right anterior shoulder, and the right and left anterior wrist; and lumbar, right, and left shoulder ranges of motion are decreased. The treatment plan has included the request for home interferential unit 30-day rental; and left knee

brace. The original utilization review dated 10-27-2015, non-certified the request for home interferential unit 30-day rental; and left knee brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home interferential unit 30 day rental: 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): Transcutaneous electrotherapy.

Decision rationale: The patient presents with pain affecting the bilateral knees, bilateral ankles, bilateral legs, bilateral lower extremities, right shoulder, right arm, right wrist and thoracic spine. The current request is for Home interferential unit 30-day rental. The treating physician report dated 6/12/15 (210B) states, "I am requesting authorization for a 1 month rental of a home interferential unit (Interspec IF II) for pain control." The MTUS Guidelines do not recommend interferential current stimulation (ICS). MTUS goes on to say that if ICS is to be used, the criteria should be based on effectiveness proven by a physician or licensed provider of physical medicine when chronic pain is ineffectively controlled with medications, history of substance abuse or from significant post-operative conditions. In this case, the medical record have not provided any information to indicate that a trial of interferential current stimulation is warranted and MTUS does not support this modality. The current request is not medically necessary.

Left knee brace: Overturned

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Activity Alteration.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG online, Knee, Brace.

Decision rationale: The patient presents with pain affecting the bilateral knees, bilateral ankles, bilateral legs, bilateral lower extremities, right shoulder, right arm, right wrist and thoracic spine. The current request is for Left knee brace. The treating physician report dated 6/12/15 (211B) states, "The patient will need brace for the right knee and left knee." The MTUS guidelines do not address the current request. The ODG guidelines recommend a knee brace for instability of the knee. In this case, the treating physician provides documentation of the patient's weakness and instability of the left knee during examination. The current request satisfies the ODG guidelines as outlined in the "Knee" chapter. The current request is medically necessary.