

<b>Case Number:</b>	CM15-0054076		
<b>Date Assigned:</b>	03/27/2015	<b>Date of Injury:</b>	08/21/2006
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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 61-year-old female who reported an injury on 12/10/2009. The mechanism of injury was not specifically stated. The current diagnoses include cervical disc protrusion, cervical myospasm, cervical sprain, right knee chondromalacia, right knee pain, right knee sprain, left knee sprain, and Baker's cyst. The injured worker presented on 01/23/2015 for a follow-up evaluation with complaints of cervical spine pain, right knee pain, and left knee pain. Upon examination, there was decreased and painful range of motion of the cervical spine, tenderness over the cervical paravertebral muscles, cervical paravertebral muscle spasm, positive cervical compression test, 0 degrees to 140 degrees range of motion of the bilateral knees, and tenderness over the anterior, lateral, and medial knee. McMurray's test was also positive bilaterally. Treatment recommendations included a referral to an orthopedic surgeon, a TENS unit, a course of physical therapy 2 times per week for 4 weeks, and 12 sessions of aquatic therapy. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Consultation with an Orthopedic Surgeon, bilateral knees:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), page 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. In this case, there is no documentation of a significant functional deficit. There is evidence of tenderness to palpation with a positive McMurray's sign; however, there are no complex orthopedic findings or any red flags for serious pathology noted. The injured worker is also pending authorization for a course of conservative treatment. In the absence of an exhaustion of conservative management, the injured worker would not be a surgical candidate. The medical necessity for the requested orthopedic surgeon referral has not been established in this case. Therefore, the request is not medically necessary.

**TENS/EMS Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS (transcutaneous electrical nerve stimulation) Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** California MTUS Guidelines do not recommend transcutaneous electrotherapy as a primary treatment modality, but a 1 month home based trial may be considered as a noninvasive conservative option. In this case, there is no documentation of chronic intractable pain or a significant functional deficit. There is also no documentation of a successful 1 month trial prior to the request for a unit purchase. Given the above, the request is not medically necessary.

**Urine Screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management; Opioids, steps to avoid misuse/addiction Page(s): 77-80, 94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77, 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

**Decision rationale:** California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented

evidence of risk stratification. Patients at low risk of addiction or aberrant behaviors should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, there is no mention of non-compliance or misuse of medication. There is no indication that this injured worker falls under a high risk category that would require frequent monitoring. Therefore, the current request is not medically appropriate.

**Follow-up with cardiac thoracic surgeon:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** California MTUS/ACOEM Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. In this case, there is no documentation of a significant abnormality to support the necessity for a cardiothoracic surgeon. The medical rationale for the requested referral was not provided. As the medical necessity has not been established, the request is not medically appropriate.

**Physical Therapy, 2 times weekly for 4 weeks, bilateral knees:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. In this case, there was no documentation of a significant functional deficit. There was also no documentation of a previous course of physical therapy with evidence of objective functional improvement. Additional treatment would not be supported. As such, the request is not medically appropriate.

**Aquatic Therapy, 12 sessions, bilateral knees:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**Decision rationale:** California MTUS Guidelines recommend aquatic therapy as an optional form of exercise therapy and as an alternative to land based physical therapy. Aquatic therapy is

specifically recommended where reduced weight bearing is desirable. In this case, there is no indication that this injured worker is incapable of participating in land based physical therapy. There is no indication that this injured worker requires reduced weight bearing. Given the above, the request is not medically appropriate.