

<b>Case Number:</b>	CM15-0059188		
<b>Date Assigned:</b>	04/06/2015	<b>Date of Injury:</b>	06/21/2014
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/28/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 female with an industrial injury dated June 21, 2014. In an addendum report dated 2/4/2015, the injured worker reported a history of anemia. The injured worker also reported that approximately three years ago she developed neck complaints and was told that she had spondylosis. She reported that prior to the work related injuries that occurred in 2014, her neck pain was infrequent and approximately a 4/10, and after injuries, her neck pain was a 7 or 8/10 and frequent. The injured worker has been treated with prescribed medications. The treating physician noted that the right elbow and right knee impairment was the result of the trip and fall injury occurring on June 21, 2014. The treating physician prescribed services for aquatic rehabilitative program, rental of home inferential muscle stimulation and electric moist heat pad and supplies for the right knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AQUATIC REHABILITATIVE PROGRAM 3X4 WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines PHYSICAL MEDICINE.

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

**Decision rationale:** According to MTUS guidelines, aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. For recommendations on the number of supervised visits, see Physical medicine. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities maybe required to preserve most of these gains. (Tomas-Carus, 2007) There no clear evidence that the patient is obese or need have difficulty performing land based physical therapy or the need for the reduction of weight bearing to improve the patient ability to perform particular exercise regimen. There is no documentation of functional benefit from previous aquatic therapy sessions. There is no clear objective documentation for the need of aquatic therapy. Therefore the prescription of AQUATIC REHABILITATIVE PROGRAM 3X4 WEEKS is not medically necessary.

**RENTAL OF HOME INTERFERENTIAL MUSCLE STIMULATION X1 MONTH:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints,Chronic Pain Treatment Guidelines TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Interferential Current Stimulation Page(s): 118-119.

**Decision rationale:** According to MTUS guidelines, "Interferential Current Stimulation (ICS). 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. (Van der Heijden, 1999)(Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005)(Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues." 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.). There is no clear evidence that the patient did not respond to conservative therapies, or have post op pain that limit his ability to perform physical therapy. There is no clear evidence that the prescription of interferential stimulator is in conjunction with other intervention. Therefore, the prescription of RENTAL OF

HOME INTERFERENTIAL MUSCLE STIMULATION X1 MONTH is not medically necessary.

**ELECTRICAL MOIST HEAT PAD AND SUPPLIES FOR THE RIGHT KNEE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.?([http://www.worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#SPECT](http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT)).

**Decision rationale:** According to ODG guidelines, cold therapy is recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel. There is no evidence to support the efficacy of hot and cold therapy in this patient. There is not enough documentation relevant to the patient work injury to determine the medical necessity for cold/hot therapy. There is no controlled studies supporting the use of hot/cold therapy in Knee pain or post op pain beyond 7 days after surgery. There is no documentation that the patient needs heat therapy. Therefore, the request for ELECTRICAL MOIST HEAT PAD AND SUPPLIES FOR THE RIGHT KNEE is not medically necessary.