

Case Number:	CM15-0083678		
Date Assigned:	05/05/2015	Date of Injury:	08/27/2004
Decision Date:	07/08/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/01/2015

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: Pennsylvania, Ohio, 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 62 year old female, who sustained an industrial injury on 8/27/04 She has reported initial complaints of low back, left hip, knee and ankle injury from repetitive motion injury. The diagnoses have included lumbar stenosis, bilateral lumbar radiculopathy with weakness, left knee degenerative joint disease (DJD), acute strain left knee/stable, thoracic spondylosis, lumbar scoliosis, and status post left knee total arthroplasty 7/30/14. Treatment to date has included medications, activity modifications, diagnostics, and surgery. Currently, as per the physician progress note dated 4/7/15, the injured worker complains of low back pain that radiates down the left thigh and calf rated 9-10/10 on pain scale. She complains of left knee pain rated 9-10/10 on pain scale and neck pain that radiates to the mid scapular region rated 9-10/10 on pain scale. The physical exam of the lumbar spine and lower extremities reveals that she walks with antalgic gait and uses a single point cane for ambulation. There is decreased sensation over the left dermatome distribution. The hip flexion motor power is decreased bilaterally. The straight leg raise is positive on the left at 80 degrees. The knee exam reveals moderate effusion of the left knee, tenderness over the medial collateral ligament on the left and minimal tenderness over the left patella. The current medications included Robaxin, Norco, Colace, Zofran and Nifediac. The urine drug screen dated 11/3/14 and 3/3/15 was consistent with the medication prescribed. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine dated 2/13/15 reveals posterior spurring, disc bulge, bilateral neural foraminal narrowing, bilateral facet joint hypertrophy, degenerative changes at the superior and inferior endplate, spinal canal stenosis, and bilateral pars defects. It is noted that she is a candidate for decompression and laminotomies and foraminotomies but is not urgent. There was no other diagnostics noted in the records and there was no previous therapies noted. Work status is temporary totally disabled until 5/19/15. The physician requested treatment included Physical therapy 2 times 6 for the left knee, Rental/purchase H-wave unit, Purchase

Neoprene knee brace and Norco 5/325 unspecified quantity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times 6 for the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS 2010 Revision, Web Edition, Page(s): 117-118 Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Web Edition.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-990.

Decision rationale: MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. This request is not medically necessary.

Rental/purchase H-wave unit: Upheld

Claims Administrator guideline: Decision based on MTUS 2010 Revision, Web Edition, Page(s): 117-118 Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Web Edition.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation Page(s): 117-118.

Decision rationale: MTUS recommends H-wave stimulation as part of an overall program of functional restoration. A one-month H-wave trial is recommended as an option for chronic soft tissue inflammation or diabetic neuropathic pain only after failure of specific first-line treatment, including PT, medications, and TENS. These guidelines have not been met. The request is not medically necessary.

Purchase Neoprene knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS 2010 Revision, Web Edition, Page(s): 117-118 Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Web Edition.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

Decision rationale: ACOEM recommends use of a knee brace only in specific well-defined situations of joint instability. The guideline suggests that the benefits of a brace may be more emotional (i. e. increasing confidence) than medical and that, usually a brace is necessary only if the patient will be stressing the joint under load. Overall ACOEM states that for the average patient, using a brace is usually unnecessary. The records do not provide such specific data

about knee instability to support an indication for this equipment. This request is not medically necessary.

Norco 5/325 unspecified quantity: Upheld

Claims Administrator guideline: Decision based on MTUS 2010 Revision, Web Edition, Page(s): 117-118 Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Web Edition.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Ongoing Management Page(s): 78.

Decision rationale: MTUS discusses in detail the 4 A's of opioid management, emphasizing the importance of dose titration vs. functional improvement and documentation of objective, verifiable functional benefit to support an indication for ongoing opioid use. The records in this case do not meet these 4As of opioid management and do not provide a rationale or diagnosis overall for which ongoing opioid use is supported. Therefore this request is not medically necessary.