

Case Number:	CM15-0086909		
Date Assigned:	05/11/2015	Date of Injury:	12/18/2014
Decision Date:	06/17/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/06/2015

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: Emergency 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 60 year old female, who sustained an industrial injury on 12/18/2014. She reported slipping and falling and injuring the right leg. Diagnoses have included lumbosacral musculoligamentous sprain/strain, right L5-S1 facet syndrome, right knee contusion and right knee internal derangement. Treatment to date has included physical therapy, facet joint injection and medication. According to the progress report dated 4/6/2015, the injured worker complained of lumbar spine pain rated 8/10 with radiation of pain to the right hip. He complained of right knee pain rated 7/10. She complained of right thigh pain rated 4/10 and right ankle/foot pain rated 6/10. The injured worker ambulated with a cane, favoring the right lower extremity. Authorization was requested for physical therapy, electrical stimulation and hydroculator for the lumbar spine and right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the lumbar spine and right knee, twice a week for three weeks:
Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Complaints, Physical Therapy.

Decision rationale: The requested Physical Therapy for the lumbar spine and right knee, twice a week for three weeks, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Low Back Complaints, Page 300 and Official Disability Guidelines, Low Back Complaints, Physical Therapy, recommend continued physical therapy with documented derived functional benefit. The injured worker has lumbar spine pain rated 8/10 with radiation of pain to the right hip. He complained of right knee pain rated 7/10. She complained of right thigh pain rated 4/10 and right ankle/foot pain rated 6/10. The injured worker ambulated with a cane, favoring the right lower extremity. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions. The criteria noted above not having been met, Physical Therapy for the lumbar spine and right knee, twice a week for three weeks is not medically necessary.

Electrical Stimulation for the lumbar spine and right knee, twice a week for three weeks:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation Page(s): 118-120.

Decision rationale: The requested Electrical Stimulation for the lumbar spine and right knee, twice a week for three weeks, is not medically necessary. CA Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120, noted that this treatment is 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. There are no published randomized trials comparing TENS to Interferential current stimulation; and the criteria for its use are: 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.). The injured worker has lumbar spine pain rated 8/10 with radiation of pain to the right hip. He complained of right knee pain rated 7/10. She complained of right thigh pain rated 4/10 and right ankle/foot pain rated 6/10. The injured worker ambulated with a cane, favoring the right lower extremity. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The criteria noted above not having been met, Electrical Stimulation for the lumbar spine and right knee, twice a week for three weeks is not medically necessary.

Hydroculator for the lumbar spine and right knee, twice a week for three weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

Decision rationale: The requested Hydroculator for the lumbar spine and right knee, twice a week for three weeks, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 8, Neck and Upper Back Complaints, Initial Care, Physical Modalities, Page 174, recommend hot and cold packs only for the first few days of initial complaints. The injured worker has lumbar spine pain rated 8/10 with radiation of pain to the right hip. He complained of right knee pain rated 7/10. She complained of right thigh pain rated 4/10 and right ankle/foot pain rated 6/10. The injured worker ambulated with a cane, favoring the right lower extremity. The treating physician has not documented the medical necessity for this DME beyond the initial first few days of treatment. The criteria noted above not having been met, Hydroculator for the lumbar spine and right knee, twice a week for three weeks is not medically necessary.