

<b>Case Number:</b>	CM14-0135687		
<b>Date Assigned:</b>	08/29/2014	<b>Date of Injury:</b>	05/01/2014
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2014

### 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. The expert reviewer is Board Certified in Internal Medicine & Emergency Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 41 year-old with a date of injury of 05/01/14. A progress report associated with the request for services, dated 07/07/14, identified subjective complaints of left elbow pain, increased with range of motion. Also right knee pain with clicking and popping. Objective findings included tenderness of the left elbow epicondyle. Tenderness and effusion was noted on the right knee. Diagnoses included (paraphrased) internal derangement of the right knee; left epicondylitis; and possible carpal tunnel syndrome. Treatment had included medications and 12 sessions of physical therapy (PT) on the right knee and left elbow. A Utilization Review determination was rendered on 07/24/14 recommending non-certification of "Pro-OTS hinged knee brace; Solar Care FIR heating system; X- force stimulator; and PT, two to three times a week for four weeks, left elbow 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 , two to three times a week for four weeks, left elbow and right knee:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Physical Medicine Treatment.

**Decision rationale:** The Chronic Pain section of the Medical Treatment Utilization Schedule (MTUS) recommends physical therapy with fading of treatment frequency associated with "... active therapies at home as an extension of the treatment process in order to maintain improvement levels." Specifically, for myalgia and myositis, 9-10 visits over 8 weeks. The Official Disability Guidelines (ODG) states that for sprains and strains of the knee, 12 visits over 8 weeks are recommended, and for arthritis and pain in the knee, 9 visits over 8 weeks. The patient has received an unspecified number of previous physical therapy sessions. An additional 12 sessions are requested, which exceeds the recommendation of a total of 12 visits. Functional improvement must be clearly defined for additional physical therapy. In this case, the record does not document previous functional improvement and therefore the medical necessity for 2-3 sessions per week for 4 weeks. Therefore the request is not medically necessary.

**X- force stimulator:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- Neuromuscular electrical stimulator.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121.

**Decision rationale:** The Claims Administrator based its decision on the Non-MTUS ODG- Neuromuscular electrical stimulator. The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Transcutaneous Electrotherapy, page 114-121. The Expert Reviewer's decision rationale: The X-force stimulator is a type of neuromuscular stimulator, which is a type of transcutaneous electrotherapy, similar to TENS, but also with Muscular Electrical Stimulation (MES). The California Medical Treatment Utilization Schedule (MTUS) states that TENS is not recommended for the back. For other conditions, a one month trial of transcutaneous therapy is considered appropriate if used as an adjunct to an evidence-based program of functional restoration. The recommended types of pain include:- Neuropathic pain- CRPS I and II- Phantom limb pain- Spasticity- Multiple sclerosis. For chronic intractable pain from these conditions, the following criteria must be met:- Documentation of pain for at least three months duration.- Evidence that other appropriate pain modalities have been tried (including medication) and failed.- A one-month trial period of the TENS unit should be documented with documentation of how often it was used, as well as the outcomes in terms of pain relief and function.- Other ongoing pain treatment should also be documented during the trial period including medication usage.- A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. In this case, the multiple criteria noted above (trial and goal plan) have not been met. The Guidelines also state that a one-month should be attempted. Therefore, there is no documented medical necessity for a Neuromuscular Stimulator unit. The request is not medically necessary.

**Solar Care FIR heating system:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Heat; Low Back, Infrared Therapy (IR).

**Decision rationale:** Solar Care FIR heating delivers heat through infrared therapy. The Medical Treatment Utilization Schedule (MTUS) states that at-home application of local heat is optional. The Official Disability Guidelines (ODG) states that heat therapy is recommended as an option. Infrared (IR) therapy is not recommended over other heat therapies. It may be used in acute low back pain, but only as an adjunct to a program of evidenced-based conservative care (exercise). Since IR therapy is not recommended over other heat therapies, there is no medical necessity for this modality without documentation of effectiveness of heat therapy in this patient. Therefore the request is not medically necessary and appropriate.

**Pro-OTS hinged knee brace:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Knee Brace.

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) states that prophylactic or prolonged bracing of the knee is not recommended. The Official Disability Guidelines (ODG) state that knee braces are recommended under the following conditions: -Knee instability-Ligament insufficiency/deficiency-Reconstructed ligament-Articular defect repair-Avascular necrosis-Meniscal cartilage repair-Painful failed total knee arthroplasty-Painful unicompartamental osteoarthritis. They further note: "In all cases, braces need to be used in conjunction with a rehabilitation program and are necessary only if the patient is going to be stressing the knee under load." In this case, the criteria for a brace are not met. Therefore, the record does not document the medical necessity for a hinged knee brace. The request is not medically necessary.