

Case Number:	CM14-0149505		
Date Assigned:	09/18/2014	Date of Injury:	07/19/2010
Decision Date:	10/17/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/15/2014

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 Chiropractic, has a subspecialty in Acupuncture and is licensed to practice in New York. 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:

Upon review of the medical records provided the applicant was a 50 year old male who was involved in an industrial injury that occurred on July 19, 2010. The records indicated that he twisted his right knee when he stepped off a street curb aggravating his persistent right knee pain. The claimant initially injured his right knee on 11/6/98 and underwent right knee arthroscopy on 7/24/99. The body parts accepted for the 7/19/10 is the right knee and lower back. Thus far, treatment has consisted of physical therapy x19 in 2011 and physical therapy 12, in 2014 to the right knee, lumbar brace, MRI of the lumbar spine performed in March of 2011 and March 4, 2014, MRI of the right knee dated June 2011, electrical stimulation and exercise. The records indicated that the results of physical therapy to the lumbar spine have been minimal to moderate in terms of improvement. Upon review of a physicians report dated 8/8/14, the applicant presented with complaints of intermittent low back pain that rated an 8/10 that intermittently radiates down the legs bilaterally with prolonged weight bearing activities. He has moderate leg pain due to radiating pain. Lumbar spine examination revealed tenderness with guarding left more than right, paraspinal musculature guarding, lumbar spine midline and lower lumbar spine tenderness. Lumbar range of motion was 90%. A diagnosis was given as: L3/4, 3mm discopathy. Treatment plan consisted of continuing exercise and stretch to tolerance, order Vital Wrap for home use and request one month trial of interferential unit and exercise kit for the lumbar spine and pain management consult within MPN for possible epidural injections. Upon review of a physician's report dated 2/28/14 it was documented that the claimant In a utilization review report dated 8/25/14, the reviewer determined a vital wrap, exercise kit and IF unit-one month trial was not medically necessary and non-certified. This was based upon the MTUS Chronic Pain Medical Treatment Guidelines and ODG Low Back Chapter Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vital wrap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Physical Therapy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation (ODG)-Low Back Chapter

Decision rationale: The applicant was a 50 year old male who was involved in an industrial injury that occurred on July 19, 2010. The records indicated that he twisted his right knee when he stepped off a street curb aggravating his persistent right knee pain. As per the ACOEM guidelines, high tech applications of heat and cold are not recommended in the treatment of any chronic pain conditions as these are considered items that applicant can perform independently. The ACOEM chapter 12 guidelines suggest that at home local applications of heat and cold are as effective as those performed by therapist or by extension by high tech means. This product represents a high-tech means of delivering a hot and cold therapy. The request for 1 vital wrap system is not medically necessary or appropriate.

Exercise kit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Physical Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise 8.C.C.R 9792.20-9792.26 Page(s): 46.

Decision rationale: The applicant was a 50 year old male who was involved in an industrial injury that occurred on July 19, 2010. The records indicated that he twisted his right knee when he stepped off a street curb aggravating his persistent right knee pain. The guidelines do recommend exercise for treatment and for prevention. There is strong evidence that exercise reduces disability duration in employees with low back pain. The guidelines do document that the key to success in the treatment of LBP is physical activity in any form, rather than through any specific activity. If exercise is prescribed a therapeutic tool, some documentation of progress should be expected. There was no specific documentation with regards to the progress of this applicant undergoing a prescribed exercise treatment regimen. While a home exercise program is of course recommended, more elaborate personal care where outcomes are not monitored by a health professional, such as gym memberships or advanced home exercise equipment may not be covered under this guideline, although temporary transitional exercise programs may be appropriate for patients who need more supervision. Chronic Pain Medical Treatment guidelines indicate there is no evidence to support the recommendation of any one particular exercise program over another. Home exercises emphasizing education and independence are endorsed as quickly as practicable. In this case, it is not clearly stated why the employee needs specialized

equipment and/or is incapable of participating in a home exercise program. It is not clearly stated what the home exercise kit represents and what it is intended to serve. The request for a home exercise kit is not medically necessary and appropriate.

IF unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Physical Therapy; Interferential Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) -8.C.C.R. 9792.20-9792.26 Page(s): 114 and page 120.

Decision rationale: The applicant was a 50 year old male who was involved in an industrial injury that occurred on July 19, 2010. The records indicated that he twisted his right knee when he stepped off a street curb aggravating his persistent right knee pain. As per the MTUS Guidelines, interferential current stimulation 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. In review of 6/9/14-8/22/14 physical therapy treatment records, they do provide that the applicant's physical therapy treatment regimen do include interferential there was no specific physician documented effectiveness. The only assessment was that therapy was tolerated. The guidelines also indicate that this may be appropriate in certain clinical setting where the pain is ineffectively controlled due to diminished effectiveness of medication, or side effects, history of substance abuse or significant pain from postoperative conditions limiting the ability to perform exercise programs/physical therapy or unresponsive to conservative measures such as ice/heat or repositioning. The guidelines suggest inferential stimulator should be reserved for patients with history of analgesic failure or intolerance; no evidence in the records shows criteria for inferential stimulator have not been met. Such as, the IF unit is not medically necessary.