

Case Number:	CM14-0217019		
Date Assigned:	01/06/2015	Date of Injury:	04/12/2011
Decision Date:	02/28/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/29/2014

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. 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: Arizona, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

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

According to the records made available for review, this is a 57-year-old female with a date of injury on 04/12/2011. Medical records provided did not indicate the injured worker's mechanism of injury. Documentation from 12/05/2014 and 08/29/2014 indicated the diagnoses of status post left total knee replacement on 05/14/2014 complicated by supracondylar femur fracture, status post open reduction internal fixation 05/30/2014, and residual weakness to left knee extension. Subjective findings from 12/05/2014 indicated improvement in range of motion, strength, and pain. The injured worker was noted to have difficulty with ambulation and was noted to be unable to walk longer than ten minutes. Physical examination from the same date was remarkable for left knee flexion of 125 degrees with 0 extension, weakness in extension rated a four out of five with atrophy to the quadriceps. X-ray noted on 12/05/2014 was revealing for further healing of the femur fracture. Prior treatments offered to the injured worker included post-operative care in a skilled nursing facility; use of a walker, cane, shower chair, wheelchair, and elevated commode seat; physical therapy at an outpatient facility and through home health; use of home bone stimulator; home exercise program; home health services; and a medication history of Tramadol and Dilaudid. Physician documentation from 12/05/2014 noted improvement in the injured worker's range of motion and strength secondary to physical therapy. Physical therapy note from 12/01/2014 indicated the injured worker to have a pain level of six out of ten and continues to need assistance with a walker out of the house secondary to fatigue. Functional status noted during this therapy session noted the injured worker to be unable to perform stair climbing, running, pivoting, and twisting. The injured worker had severe limitation

for activities of driving and walking for long periods of time. Documentation indicated moderate limitation for standing and walking for short periods and mild limitation for dressing. The treating physical therapist noted an improvement to the injured worker. Medical records provided included multiple physical therapy notes however; there was no documentation of the total quantity of physical therapy sessions provided to the injured worker to date. Medical records from 12/05/2014 noted a work status of temporarily totally disabled. On 12/12/2014, Utilization Review non-certified the prescriptions for physical therapy to the left knee three times four, neuromuscular stimulator (three month rental), and stimulator garment (three month rental). The physical therapy was noncertified based on Chronic Pain Medical Treatment Guidelines, with the Utilization Review noting that the medical records provided lacked documentation on physical therapy notes with documentation of functional progress. Utilization Review noncertified neuromuscular stimulator based on Chronic Pain Medical Treatment Guidelines with the Utilization Review noting that there was a lack of documentation indicating the injured worker underwent neuromuscular stimulation in a clinical setting with noted functional improvement. Utilization Review noncertified stimulator garment with the Utilization Review noting that the requested neuromuscular stimulator is not medically necessary, therefore the request for stimulator garment is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3 times a week for 4 weeks (left knee): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Knee pain and therapy

Decision rationale: According to the MTUS guidelines, therapy is recommended in a fading frequency. They allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The following diagnoses have their associated recommendation for number of visits. Myalgia and myositis, unspecified 9-10 visits over 8 weeks, Neuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeks. According to the ODG guidelines, up to 18 visits are recommended for post-surgical femure fractures. In this case, the claimant had an initial physical therapy visit after the surgery in August 2014. Twelve sessions of therapy were ordered in September 2015. The amount of sessions completed is unknown. The request for 12 additional sessions is not medically necessary.

Neuromuscular stimulator (3-month-rental): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Neuromuscular stimulator Page(s): 113-115, 120.

Decision rationale: According to the MTUS guidelines, a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. This is similar to a neuromuscular stimulator. It is recommended for the following diagnoses: CRPS, multiple sclerosis, spasticity due to spinal cord injury and neuropathic pain due to diabetes or herpes. In this case, the claimant did not have the above diagnoses. There was no mention of response to its use over a month period. In addition, a Neuromuscular stimulator is not recommended by the guidelines. The request for a neuromuscular stimulator unit is not medically necessary.

Stimulator garment (3-month-rental): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Neuromuscular stimulator Page(s): 113-115, 120.

Decision rationale: According to the MTUS guidelines, a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. This is similar to a neuromuscular stimulator. It is recommended for the following diagnoses: CRPS, multiple sclerosis, spasticity due to spinal cord injury and neuropathic pain due to diabetes or herpes. In this case, the claimant did not have the above diagnoses. There was no mention of response to its use over a month period. In addition, a Neuromuscular stimulator is not recommended by the guidelines. The request for a neuromuscular stimulator unit is not medically necessary and therefore the garments are not medically necessary.