

Case Number:	CM14-0218938		
Date Assigned:	01/09/2015	Date of Injury:	06/15/2006
Decision Date:	03/10/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/30/2014

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 44 year old male, who sustained an industrial injury on 06/15/2006. He has reported subsequent low back, right leg and left knee pain and was diagnosed with myoligamentous lumbar spine sprain/strain, degenerative disc disease, lumbar spondylosis and above the knee amputation of the right lower extremity. Treatment to date has included oral pain medication, lower extremity prosthesis and physical therapy. There is minimal documentation in the medical record. Currently the IW complains of continued frequent sharp low back, right leg and left knee pain rated as 5-6 out of 10. Physical examination findings revealed tenderness to palpation of the lumbar spine. The IW was noted to walk with a markedly altered gait without assistive devices. The physician indicated that the IW had not undergone any conservative treatment for greater than a year but that previous physical therapy treatments and a prosthetic device had helped to reduce signs and symptoms in the past. A prior request had been made and denied according to physician documentation. Another request was made for PT, right lower extremity prosthesis and a Meds-4 interferential unit with garment for home use. On 12/08/2014, Utilization Review non-certified a request for 8 visits of physical therapy, right lower extremity prosthesis and a Meds-4 interferential unit with garment for home use. The UR physician noted that it was unclear as to how many sessions of PT were previously received or documentation of any specific functional improvement with treatment, that there was no discussion as to why the IW's previous lower extremity prosthesis needed to be replaced and that interferential current

stimulation was not recommended as an isolated intervention. MTUS chronic pain and ODG guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x 8 for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Additionally, ACOEM guidelines advise against modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a six-visit clinical trial of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. The treating physician does not state how many physical therapy visits the patient has attended and the outcome of those visits. In addition, there is no documentation of functional improvement from previous therapy and why a home exercise program is not sufficient. As such, the request for Physical therapy x 8 for the lumbar spine is not medically necessary.

Right lower extremity prosthesis: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and leg, Prostheses (artificial limb)

Decision rationale: ODG states "Recommended as indicated below. A prosthesis is a fabricated substitute for a missing body part. Lower limb prostheses may include a number of components, such as prosthetic feet, ankles, knees, endoskeletal knee-shin systems, socket insertions and suspensions, lower limb-hip prostheses, limb-ankle prostheses, etc. See also Microprocessor-controlled knee prostheses. Criteria for the use of prostheses: A lower limb prosthesis may be considered medically necessary when: 1. The patient will reach or maintain a defined functional state within a reasonable period of time; 2. The patient is motivated to ambulate; and 3. The prosthesis is furnished incident to a physician's services or on a physician's order. Prosthetic

knees are considered for medical necessity based upon functional classification, as follows:(a) A fluid or pneumatic knee may be considered medically necessary for patients demonstrating a functional Level 3 (has the ability or potential for ambulation with variable cadence, typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion), or above. (b) A single axis constant friction knee and other basic knee systems are considered medically necessary for patients demonstrating a functional Level 1 (has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence, typical of the limited and unlimited household ambulator), or above. (c) A high-activity knee control frame is considered medically necessary for patients whose function level is 4. (has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete), or above.(d) Microprocessor-controlled leg prostheses (e.g., Otto Bock C-Leg, Intelligent Prosthesis, and Ossur Rheo Knee) are considered medically necessary in otherwise healthy, active community ambulating adults (18 years of age or older) demonstrating a functional Level 3, or above, with a knee disarticulation amputation or a trans-femoral amputation from a non-vascular cause (usually trauma or tumor) for whom this prosthesis can be fitted and programmed by a qualified prosthetist trained to do so. (Sansam, 2009)”. The patient has a previous right lower extremity prosthesis. The treating physician does not detail why a replacement prosthesis is needed or why the current prosthesis is no longer appropriate. As such, the request for a right lower extremity prosthesis is not medically necessary at this time.

Meds-4 Interferential unit with garment for home use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation Pain, TENS chronic pain (transcutaneous electrical nerve stimulation)

Decision rationale: ACOEM guidelines state Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists. MTUS further states regarding interferential units, not recommended as an isolated intervention and details the criteria for selection:- 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.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. The treating physicians progress notes do not indicate that the patient has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise

programs/treatments, or is unresponsive to conservative measures. As such, current request for Meds-4 Interferential unit with garment for home use is not medically necessary.