

Case Number:	CM15-0065612		
Date Assigned:	04/13/2015	Date of Injury:	04/01/2014
Decision Date:	05/21/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	04/07/2015

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: New York, Tennessee
 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 54-year-old female, with a reported date of injury of 04/01/2014. The diagnoses include status post right knee arthroscopy with residual sprain/strain and patellofemoral crepitus, lumbar spine musculoligamentous sprain/strain, left knee sprain with patellofemoral arthralgia, and right foot sprain. Treatments to date have included cold packs, oral medications, an MRI of the right knee, right knee arthroscopy, twelve (12) physical therapy sessions, a cane, two cortisone injections, a Synvisc injection, and x-rays of the lumbar spine, right knee, and right foot. The Doctor's First Report dated 01/30/2015 indicates that the injured worker complained of low back pain, bilateral knee pain, and right foot pain. The physical examination of the low back showed tenderness to palpation over the bilateral paraspinal muscles with spasm on the left sacroiliac joint, positive straight leg raise test with pain, and decreased range of motion. An examination of the bilateral knees showed tenderness to palpation over the medial joint lines, lateral joint lines, and peripatellar regions, bilateral patellofemoral crepitus with passive ranging, and a slight antalgic gait favoring the right leg. An examination of the right foot showed tenderness to palpation over the dorsal aspect of the foot, and intact sensation in the bilateral lower extremities. The treating physician requested twelve (12) physical therapy sessions or an unspecified body part, a home interferential unit for the right lower extremity, and orthotics for the right lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy to unspecified body parts, three times weekly for four weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 98-99.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Recommended number of visits for myalgia and myositis is 9-10 visits over 8 weeks; and for neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks. In this case the requested number of 12 visits surpasses the number of six recommended for clinical trial to determine functional improvement. The request IS NOT medically necessary.

Home interferential unit, right lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114, 118 - 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 118-119.

Decision rationale: Interferential current stimulation (ICS) 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. ICS is indicated when pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, there is a history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, or the pain is unresponsive to conservative measures. If criteria are met, there should be a one-month trial to permit the physician and physical medicine provider to study the effects and benefits. In this case, documentation does not support that the ICS is to be used in conjunction with other treatments. In addition, there is no documentation of successful one-month home trial. The request IS NOT medically necessary.

Orthotics, right lower extremity: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Ankle & Foot, Orthotic Devices.

Decision rationale: Orthotic devices are recommended for plantar fasciitis and for foot pain in rheumatoid arthritis. Both prefabricated and custom orthotic devices are recommended for plantar heel pain. Ankle foot orthosis is recommended as an option for foot drop. An ankle foot orthosis (AFO) also is used during surgical or neurologic recovery. In this case there is insufficient documentation to support the diagnoses of plantar fasciitis, rheumatoid arthritis, or foot drop. The request IS NOT medically necessary.