

Case Number:	CM15-0066385		
Date Assigned:	04/14/2015	Date of Injury:	10/23/2014
Decision Date:	06/29/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/08/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 38 year old female, who sustained an industrial injury on 10/23/2014. She reported pain in her neck, mid back, right shoulder and left knee. Diagnoses have included cervical/trapezial musculoligamentous sprain/strain; thoracolumbar musculoligamentous sprain/strain; bilateral shoulder periscapular sprain/strain and left knee sprain/strain. Treatment to date has included physical therapy and medication. According to the progress report dated 3/13/2015, the injured worker complained of bilateral shoulder pain, left greater than right, neck pain, mid and low back pain, left knee pain and sleep difficulties. Exam of the cervical spine revealed mild tenderness to palpation and spasm. Exam of the thoracic spine and lumbar spine revealed mild tenderness to palpation and spasm. There was tenderness to palpation over the bilateral shoulders and the left knee. Authorization was requested for physical therapy, an Interferential Stim Unit one month rental, a custom osteoarthritic knee brace and lumbosacral support.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 x per week x 4 weeks (12 sessions): Upheld

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

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

Decision rationale: The patient presents with neck, mid back, right shoulder, and left knee pain. The patient is not post-surgical. The physician is requesting PHYSICAL THERAPY THREE TIMES PER WEEK TIMES FOUR WEEKS 12 SESSIONS. The RFA dated 03/13/2015 shows a request for physical therapy three times per week for four weeks to the neck, back, bilateral shoulders and left knee. The patient is currently on modified duty. The MTUS Guidelines page 98 and 99 on physical medicine recommends 8 to 10 visits for myalgia, myositis, and neuralgia type symptoms. The 02/20/2015 physical therapy report shows decreased pain to the thoracic spine with reports of pain to the lumbar spine more significantly today. The 03/05/2015 physical therapy report noted thoracic and lumbar spine pain that is "tolerable." There is improvement in range of motion. The physician requested physical therapy on 03/13/2015 to reduce pain and spasm and increase motion and strength. Medical records show a total of 11 physical therapy visits to date. In this case, the patient has received a total of 11 visits recently and the requested 12 sessions would exceed MTUS guidelines. The patient should now be able to start a home-based exercise program to improve strength, range of motion and flexibility. The request IS NOT medically necessary.

Interferential Stimulation Unit, 1 month rental (including electrodes, power pack, adhesive remover towel, and leadwire): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: The patient presents with neck, mid back, right shoulder, and left knee pain. The patient is not post-surgical. The physician is requesting INTERFERENTIAL STIMULATION UNIT, ONE-MONTH RENTAL INCLUDING ELECTRODES, POWERPACK, ADHESIVE REMOVER TOWELS, AND LEAD WIRES. The RFA dated 03/13/2015 shows a request for home interferential unit. The patient is currently on modified duty. MTUS pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated Intervention, Patient selection criteria if Interferential stimulation Is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical Medicine:- 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. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction."The record show that the patient has not tried an IF unit in the past. The treatment report dated 03/13/2015 shows mild tenderness to palpation and spasm over the paraspinal musculature of the cervical,

thoracic and lumbar spine. Impingement test is positive on the left shoulder. Tenderness to palpation is present over the medial joint line and peripatellar region. Sensation to pinprick and light touch in the upper and lower extremities are intact. The physician is requesting an interferential unit to help control pain and spasm and to reduce medication use. Given the patient's symptoms, a trial of an IF unit is appropriate to determine its effects and benefits of use. The request IS medically necessary.

Custom osteoarthritic 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): 340. Decision based on Non-MTUS Citation Official disability guidelines knee chapter, knee brace.

Decision rationale: The patient presents with neck, mid back, right shoulder, and left knee pain. The patient is not post-surgical. The physician is requesting CUSTOM OSTEOARTHRITIC KNEE BRACE. The RFA dated 03/13/2015 shows a request for custom osteoarthritic knee brace. The patient is currently on modified duty. ACOEM Guidelines page 340 states, "A brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medial collateral ligament (MCL) instability, although its benefits may be more emotional than medical." The ODG Guidelines under the knee chapter does recommend knee brace for the following conditions, "Knee instability, ligament insufficient, reconstruction ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unit compartmental OA, or tibial plateau fracture." Examination of the left knee from 03/13/2013 shows no evidence of swelling, atrophy or deformity. There is tenderness to palpation over the medial joint line and peripatellar region. Patellofemoral crepitus is present with passive motion. Increased pain is experienced with Valgus stress test. No MRI or x-ray reports were provided for review to determine whether or not this patient presents with any of the conditions that a knee brace is supported per guidelines. In this case, the physician does not provide a diagnoses for which a knee brace may be indicated. The request IS NOT medically necessary.

Lumbosacral support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar Supports.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official disability guidelines Low Back chapter, lumbar supports.

Decision rationale: The patient presents with neck, mid back, right shoulder, and left knee pain. The patient is not post-surgical. The physician is requesting LUMBOSACRAL SUPPORT. The RFA dated 03/13/2015 shows a request for lumbosacral support. The patient is currently on modified duty. The ACOEM Guidelines page 301 on lumbar bracing states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under the Low Back chapter on lumbar supports states, "Not recommended for prevention; however, recommended as an option for compression fracture and specific treatment

of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain, very low quality evidence, but may be a conservative option." The examination from 03/13/2015 shows a mild increase in the lumbar lordosis curvature. Mild tenderness to palpation and spasm is present over the paraspinal musculature of the lumbar spine. Straight leg raise is negative. The physician is requesting a lumbosacral support to provide stability and reduce strain on the low back while performing activities of daily living. No MRI or x-ray reports of the lumbar spine were made available for review. The patient does not have a diagnosis of spondylolisthesis or instability and she is not post-surgical. In this case, the patient does not meet the ACOEM and ODG guidelines for lumbar support. The request IS NOT medically necessary.