MAXIMUS Federal Services

Case Number:	CM13-0014971		
Date Assigned:	12/11/2013	Date of Injury:	10/20/2010
Decision Date:	01/24/2014	UR Denial Date:	07/31/2013
Priority:	Standard	Application Received:	08/22/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Ohio and Texas. 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 physician 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:

The patient is a 60-year-old female who reported a work related injury on 10/20/2010 due to a fall. The patient sustained injury to the left knee, right elbow, and right shoulder. Magnetic resonance imaging (MRI) of the left knee revealed a tear of the meniscus, arthritis, and a lesion on the tibia with degenerative changes. The patient underwent left knee surgery on 03/01/2013 to include synovectomy, medial meniscectomy, chondroplasty, and lateral release. The request includes American Imex, electrodes and an IF unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro DOS 3/1/2013 American Imex QTY: 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-117. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter, Durable Medical Equipment.

Decision rationale: The clinical note dated 04/22/2013 indicated the employee was status post left knee surgery. The employee was wearing a brace on the left knee and using a walker. The

employee continued to have residual pain and weakness. The employee also had shoulder complaints which had gotten worse and was relying on the walker. The employee had not had therapy. The treatment plan was noted for the employee to start therapy and was given Norco at the employee's request. On the date of surgery, there was request for different durable medical goods to include an American Imex. The ODG guidelines indicate that durable medical equipment is recommended generally if there was a medical need and if the device or system meets Medicare's definition of durable medical equipment. There was a lack of documentation stating the employee's need for this equipment. There was no time noted to ascertain the result of the surgery before the equipment was ordered. Per guideline criteria, durable medical equipment is generally not used as an isolated intervention but used as an adjunct to a program of evidence based functional restoration and usually following failure of initially recommended conservative care to include physical therapy. The request for retro DOS 03/01/2013 American Imex is non-certified.

Retro DOS 3/1/2013 IF Unit QTY: 1.00: Upheld

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

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

Decision rationale: Recent clinical documentation indicated the employee was status post left knee surgery and continued to have residual pain and weakness. The employee continued to rely on a walker and a brace for the left knee. The clinical note dated 04/22/2013 indicated the employee had not had therapy yet. California Chronic Pain Medical Treatment Guidelines indicate that an interferential current stimulation unit is not recommended as an isolated intervention. An interferential stimulation unit may be appropriate for patients where pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, a patient has a history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, or the patient is unresponsive to conservative measures. There is a lack of documentation stating the employee had significant pain from the surgery or was unresponsive to conservative measures per guideline criteria for interferential stimulation. Therefore, the request for retro DOS 03/01/2013 IF unit, quantity 1 is non-certified.

Retro DOS 3/1/2013 Electrodes (18 pair/units) QTY: 1.00: Upheld

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

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

Decision rationale: The clinical note dated 04/22/2013 indicated the employee was status post left knee surgery. California Chronic Pain Medical Treatment Guidelines indicate that durable

medical equipment such as TENS units, IF units, and H-wave units should be used as an adjunct to a program of evidence based functional restoration and only following failure of initially recommended conservative care to include recommended physical therapy. The durable medical equipment was ordered on the day of surgery; therefore, the results of the surgery were unknown as of that time. The employee was not noted to be participating in a physical therapy program. Interferential current stimulation units involves the use of 2 pairs of electrodes and most units allow variation in wave form, stimulus frequency and amplitude, or intensity, and the currents rise and fall at different frequencies. The interferential current stimulation unit was not shown to be medically necessary. Therefore, the request for electrodes is non-certified.