MAXIMUS Federal Services

Case Number:	CM13-0020812		
Date Assigned:	12/11/2013	Date of Injury:	09/06/2012
Decision Date:	08/18/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/06/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/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 injured worker is a 53-year-old male who reported an injury on 09/06/2012 after an altercation at work. The injured worker reportedly sustained an injury to his low back and bilateral knees. The injured worker's treatment history included physical therapy, acupuncture, and multiple medications. The patient underwent a preoperative history and physical on 07/18/2013 that documented the patient was a surgical candidate due to chondromalacia changes. The injured worker underwent surgical intervention of the right knee on 07/18/2013. The injured worker was evaluated on 08/19/2013. It was noted that the patient had continued pain complaints of the bilateral shoulders, knees, and low back. Objective findings included 4 well healed arthroscopic portals at the right knee, pain with lumbar extension, a positive straight leg raising test, tenderness to palpation of the spinous process from the L4 to the S1, and restricted and painful range of motion of the bilateral shoulders. The injured worker's diagnoses included bicipital tendonitis of the bilateral shoulders, musculoligamentous sprain of the lumbar spine, disc extrusion at the L5-S1, bilateral knee contusions, and chondromalacia patella of the bilateral knees. A request was made for postoperative physical therapy. It was noted that an authorization request was pending for a continuous passive motion machine, a multi stimulator unit, and a Q-Tech recovery system.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTINUOUS PASSIVE MOTION RENTAL UNIT PER DAY: QTY: 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Continuous Passive Motion (CPM).

Decision rationale: The requested continuous passive motion rental unit per day for 30 days is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines recommend the use of a continuous passive motion machine in the postsurgical management of a total knee replacement. Other surgical indications do not benefit from the use of a continuous passive motion unit and are not supported by guideline recommendations. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested continuous passive motion renal unit per day, quantity 30 is not medically necessary or appropriate.

KNEE PAD (PURCHASE): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Continuous Flow Cryotherapy.

Decision rationale: The requested knee pad for purchase is not medically necessary or appropriate as the associated equipment, Q-Tech recovery system, is not supported.

Q-TECH RECOVERY SYSTEM RENTAL UNIT (PER DAY): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 38.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Continuous Flow Cryotherapy.

Decision rationale: The requested Q-Tech recovery rental unit (per day) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do recommend the use of a Q-Tech recovery system for up to 7 days in the postsurgical management of a knee injury. The clinical documentation does support that the injured worker underwent knee surgery. However, the request as it is submitted does not clearly identify duration of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Q-Tech recovery system rental unit per day is not medically necessary or appropriate.

KNEE PAD WRAP FOR Q-TECH RECOVERY SYSTEM (PURCHASE): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 38.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)Knee and Leg Chapter, Continuous Flow Cryotherapy Unit.

Decision rationale: The requested knee pad wrap for q-tech recovery system (purchase) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do recommend the use of a Q-Tech recovery system for up to 7 days in the postsurgical management of a knee injury. The clinical documentation does support that the injured worker underwent knee surgery. However, the request as it is submitted does not clearly identify duration of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested knee pad wrap for q-tech recovery system (purchase) is not medically necessary or appropriate.

X-FORCE STIMULATOR UNIT (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION-TENS) RENTAL (PER DAY): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 116.

Decision rationale: The requested X-Force stimulator unit (transcutaneous electrical nerve stimulation-TENS) rental (per day) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of a TENS unit for up to 30 days in the postsurgical management of a knee injury. The clinical documentation submitted for review does indicate that the patient has undergone knee surgery and would benefit from a TENS unit in the postsurgical stage of the patient's recovery; however, the request as it is submitted does not clearly identify duration of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested X-Force stimulator unit (transcutaneous electrical nerve stimulation-TENS) rental (per day) is not medically necessary or appropriate.

ELECTRICAL STIMULATOR SUPPLIES, 2 LEADS (PER MONTH): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 116.

Decision rationale: As the requested X-Force stimulator unit is not medically necessary or appropriate, the ancillary supplies would also not be supported.

LEAD WIRES (PER MONTH): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENs Unit Page(s): 116.

Decision rationale: As the requested X-Force stimulator unit is not medically necessary or appropriate, the ancillary supplies would also not be supported.

REPLACEMENT BATTERIES (PER MONTH): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENs Unit Page(s): 116.

Decision rationale: As the requested X-Force stimulator unit is not medically necessary or appropriate, the ancillary supplies would also not be supported.

FORM FITTING CONDUCTIVE GARMENT (PURCHASE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENs Unit Page(s): 116.

Decision rationale: As the requested X-Force stimulator unit is not medically necessary or appropriate, the ancillary supplies would also not be supported.

HALF LEG WRAP (PURCHASE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENs Unit Page(s): 116.

Decision rationale: As the requested X-Force stimulator unit is not medically necessary or appropriate, the ancillary supplies would also not be supported.