

Case Number:	CM13-0054084		
Date Assigned:	12/30/2013	Date of Injury:	01/14/2008
Decision Date:	04/14/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	11/19/2013

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 Orthopedic Surgery and is licensed to practice in Arizona. 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:

This is a 59-year-old male who sustained a work related injury to his right knee on January 14, 2008. He underwent right knee arthroscopy on July 15, 2008 with continued right knee pain and stiffness. He continued working his regular duties with difficulty; complaining of continuing swelling, tenderness, and giving way of the knee. He continued to compensate for his right knee pain by preferentially using his left lower extremity at work and this caused increasing pain in his left knee. Evaluation of the left knee revealed a tear of the medial meniscus with malalignment of the patellofemoral joint. Evaluation of the right knee revealed a recurrent tear of the medial meniscus of the right knee with patellofemoral arthrosis and chronic malalignment. The patient was approved for arthroscopy of the left knee to treat the torn medial meniscus and the patella malalignment. This would be followed by arthroscopy of the right knee to treat the patella malalignment and arthrosis and the recurrent meniscal tear. On October 22, 2013 the patient underwent an arthroscopy of the left knee; he had a partial medial meniscectomy, a lateral retinacular release, and the medial capsular reefing. A follow-up visit on December 11, 2013 noted increased improvement of the left knee but continued pain in the right knee. The following items were requested prior to the arthroscopy of the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT PURCHASE WITH PAD, QUANTITY: 1.00: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC, Work Loss Data Institute, ODG Treatment in Workers Compensation, 10th Edition, Knee and Leg, Continuous Flow Cryotherapy.

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

Decision rationale: The ODG states: Cold Therapy Unit is recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. In comparing continuous cold therapy devices to simple icing, one study found that there was better night time pain control and improved quality of life in the early period following routine knee arthroscopy with a continuous cold therapy device. Since these devices are relatively inexpensive, easy to use, and have a high level of patient satisfaction, the ODG believes that cryotherapy is justified in the postoperative management of knee surgery and therefore, is deemed medically necessary.

SS4 ELECTRICAL STIMULATION UNIT PURCHASE, QUANTITY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Post-operative Pain (Transcutaneous Electrical Nerve Stimula.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Therapy Page(s): 116.

Decision rationale: SS4 is a multi-modal interferential stimulator that is used for pain control as well as muscle stimulation. The MTUS guidelines recommends TENS (transcutaneous electric nerve stimulation) treatments as an option for the acute postoperative pain in the first 30 days post-surgery. It is most effective in thoracotomy pain but it has been shown to be of the lesser effect or not at all for other orthopedic procedures. A rental would be preferred over purchase during this 30 day treatment. Therefore, the medical necessity of purchasing an electrical stimulation unit has not been established.

STERILE ELECTRODE PACKS, QUANTITY: 1.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the medical necessity of purchasing an interferential electrical unit has not been established, the supplies related care unit cannot be considered medically necessary.

NON STERILE ELECTRODE PACKS, QUANTITY: 3.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the medical necessity of purchasing an interferential electrical unit has not been established, the supplies related care unit cannot be considered medically necessary.

POWER PACKS, QUANTITY: 12.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the medical necessity of purchasing an interferential electrical unit has not been established, supplies relating to that unit cannot be considered medically necessary.

ADHESIVE REMOVER TOWEL MINT, QUANTITY: 16.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the medical necessity of purchasing an interferential electrical unit has not been established, then supplies relating to that unit cannot be considered medical necessary.

TT AND SS LEADWIRE, QUANTITY: 1.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the medical necessity of purchasing an interferential electrical unit has not been established, then supplies relating to that unit cannot be considered medical necessary.