

Case Number:	CM13-0056198		
Date Assigned:	05/07/2014	Date of Injury:	05/03/2002
Decision Date:	07/09/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	11/22/2013

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, has a subspecialty in Sports Medicine 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 51-year-old male who reported an injury on 05/03/2002. The mechanism of injury was not provided for review. The injured worker's treatment history included physical therapy, injections, medications, bracing, and activity modifications. The injured worker underwent an MRI of the right knee which concluded there were moderate osteoarthritic changes of the patellofemoral joint, chondromalacia, and a possible grade 2 tear of the medial patellar articular cartilage and evidence of lateral meniscus degeneration. The injured worker was evaluated on 09/23/2013. It was documented that the injured worker had persistent instability of the right knee. Physical findings included patellar instability in the right knee. It was documented that the injured worker had x-rays of the right knee that showed significant patellar tilt. However, the date was not provided. The injured worker's diagnoses included lateral patellofemoral malalignment. A request was made for a diagnostic and operative arthroscopy of the right knee with subcutaneous lateral release and medical capsular repair with postoperative physical therapy, the use of a cold unit, and a SS4 electrical stimulator unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

DIAGNOSTIC AND OPERATIVE ARTHROSCOPY OF THE RIGHT KNEE WITH SUBCUTANEOUS LATERAL RELEASE AND MEDICAL CAPSULAR REPAIR:

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), Knee & Leg Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

Decision rationale: The American College of Occupational and Environmental Medicine recommends surgery of the knee and leg when there is documentation of significantly impaired function supported by an imaging study that has failed to progress with conservative treatment that would benefit from surgical repair. The clinical documentation submitted for review does indicate that the injured worker has instability of the knee with an x-ray that supports significant patellar tilt. The injured worker has persistent symptoms that have failed physical therapy, injections, medication, bracing and activity modifications. The lateral release is the appropriate procedure for the patellar tilt component of the requested surgery. Additionally, the request includes a "medical capsular repair" and appears to be a typographical error for a "medial capsular repair." This is typically addressed intra-operatively after a lateral release to correct a patellar subluxation component if the lateral release does not adequately address the deformity. As such, the requested diagnostic and operative arthroscopy of the right knee with subcutaneous lateral release and medical capsular repair is medically necessary and appropriate.

POST-OPERATIVE 12 SESSIONS OF PHYSICAL THERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: California Medical Treatment Utilization Schedule recommends 12 visits of physical therapy in the post-surgical management of the requested surgery. However, California Medical Treatment Utilization Schedule recommends an initial course of treatment equal to half the number of recommended visits to establish efficacy of treatment. Although post-surgical physical therapy would be appropriate, the request exceeds the recommended initial course of treatment of 6 visits. There are no exceptional factors provided to support extending treatment beyond guideline recommendations. As such, Post-Operative 12 Sessions of Physical Therapy is not medically necessary or appropriate.

PURCHASE OF A COLD THERAPY UNIT: 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), 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 and Leg Chapter, Continuous Flow Cryotherapy.

Decision rationale: California Medical Treatment Utilization Schedule does not address continuous flow cryotherapy units. Official Disability Guidelines recommend the use of this type of equipment to assist with post-surgical pain control for up to seven days. Therefore a rental for seven days would be appropriate for this patient according to guidelines recommendations. However, the request is for the purchase of the unit. There were not exceptional factors provided within the documentation to support extending treatment beyond guidelines recommendations. As such, the requested Purchase of a Cold Therapy Unit is not medically necessary or appropriate.

PURCHASE OF A SS4 ELECTRICAL STIMULATOR UNIT: 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), Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post operative pain (transcutaneous electrical nerve stimulation), Interferential Current Stimulation (ICS), Neuromuscular electrical stimulation (NMES devices), and Galvanic Stimulation Page(s): 114, 118, 121, 117.

Decision rationale: The requested unit is a combination unit that includes a TENS unit, Interferential Current Stimulation (ICS), Neuromuscular electrical stimulation (NMES devices), and Galvanic Stimulation. California Medical Treatment Utilization Schedule does not support the use of Galvanic stimulation as it is considered investigational. California Medical Treatment Utilization Schedule also does not support the use of a neuromuscular electrical stimulation device unless it used in the rehabilitation process of a stroke victim. The use of a TENS unit and Interferential Current Stimulation unit is recommended by California Medical Treatment Utilization Schedule for up to 30 days in the post-surgical management of a patient's pain. This requested device includes modalities that are not supported by guidelines recommendations; therefore, it would not be supported. Additionally, the request is for purchase versus a rental. As the use of the unit, in this clinical situation, would only be supported for 30 days, purchase of the equipment would not be appropriate. As such, the requested Purchase of a SS4 Electrical Stimulator Unit is not medically necessary or appropriate.