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| Case Number: | CM13-0058028 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 09/27/2010 |
| Decision Date: | 03/27/2014 | UR Denial Date: | 11/20/2013 |
| Priority: | Standard | Application Received: | 11/26/2013 |

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 Occupational 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 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 52 year old male who was injured on 09/27/2010. He pivoted, his left knee buckled inward and he had significant pain. Prior treatment history has included therapy, pain management, home program, ultrasound, electrical stimulation, and knee brace. The patient underwent an ACL replacement and repair of a torn meniscus 3/27/2011. Medications included: 10/07/2013, Hydrocodone 10/07/2013 acetaminophen 10/07/2013 Soma 10/07/2013 Lipitor 10 mg Clinic note dated 10/07/2013 documented the patient to have complaints of left knee pain. Objective findings on exam included musculoskeletal exam revealed pain in his left knee that was continuous. His knee snapped, popped and gave out towards the inner aspect. He had swelling. He had pain standing, walking, kneeling and going up and down stairs. His knee felt unstable with walking. The pain was diffuse, but most prominent below the patella. There was no calf or medial saphenous pain. His skin scarring showed healed portals/medial tibial incision, left knee. Range of motion revealed flexion at 135 right, 135 left. Extension: 0 right, 0 left. Muscle strength of the knee was 5/5 with respect to flexors and extensors. The patient was diagnosed with persistent pain right knee, status post ACL reconstruction and repair of medial meniscus, patellofemoral chondromalacia, possible mild patellar tendinitis, mild degenerative arthritis, and possible reflex sympathetic dystrophy. Clinic note dated 10/05/2013 documented the patient to have complaints of increased clicking and locking into the left knee. Objective findings on exam included continued to demonstrate quadriceps atrophy. Strength was 3/5 to 3+/5 in the quadriceps and 4/5 to 4-/5 in the hamstrings on the left. Range of motion of the left knee revealed extension at 5 degrees and Flexion at 105 degrees. Testing was poorly tolerated and there was moderate medial joint line tenderness. Clinic note date 01/07/2013 documented the claimant had pitting edema in the left calf. On the left, he had some loss of quadriceps definition. He did have Lachman's at +1. He had some patellar crepitus and pain on patellar

compression. He had a mildly positive pivot shift test. He had an anterior drawer sign but with an endpoint. He had joint line tenderness, both medially and laterally but no collateral laxity. He has relative quadriceps and hamstring weakness on the left compared to the right at about 4/5. The claimant was at maximal medical improvement as of January 6, 2012 as determined by ■■■. ■■■. TENS unit was recommended as an option for patients in a therapeutic exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Muscle Stimulator supplies Electrodes, batteries, leadwires, etc: 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), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114.

Decision rationale: According to the available records, there has been no functional improvement or pain reduction secondary to use of muscular stimulation devices in this patient. Therefore, muscle stimulator supplies are non-certified.