

Case Number:	CM13-0059181		
Date Assigned:	12/30/2013	Date of Injury:	05/08/2009
Decision Date:	05/07/2014	UR Denial Date:	11/06/2013
Priority:	Standard	Application Received:	12/01/2013

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 Anesthesiology, has a subspecialty in Acupuncture & Pain 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:

50y/o female injured worker with date of injury 6/8/09 with related pain in the right knee and low back. Prolonged sitting and walking aggravates this pain. On examination, the bilateral knees had painful ranges of motion and were generally tender. She was diagnosed with medial meniscus tear right knee; posterior horn tear right knee. A left knee surgery was performed in 9/2009, and a second surgery in 3/2010. She has been treated with physical therapy and medication management. The date of UR decision was 11/06/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTRAST AQUA THERAPY AND SUPPLIES (WATER CIRCULATING PAD AND WRAP) FOR SIX WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Cryoanalgesia And Therapeutic Cold.

Decision rationale: The MTUS and ODG are silent on contrast aqua therapy. However, per ODG TWC, "Aetna considers the use of Hot/Ice Machine experimental and investigational for

reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source." The documentation submitted for review does not indicate why this treatment is prescribed over standard passive hot and cold packs. Medical necessity cannot be affirmed.

TWO (2) HINGED KNEE BRACES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

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

Decision rationale: Per ODG TWC: Criteria for the use of knee braces: Prefabricated knee braces may be appropriate in patients with one of the following conditions: 1. Knee instability 2. Ligament insufficiency/deficiency 3. Reconstructed ligament 4. Articular defect repair 5. Avascular necrosis 6. Meniscal cartilage repair 7. Painful failed total knee arthroplasty 8. Painful high tibial osteotomy 9. Painful unicompartmental osteoarthritis 10. Tibial plateau fracture. The injured worker does not have any of the conditions meeting the criteria for knee braces. The request is not medically necessary.

ONE (1) KNEE HOME EXERCISE REHAB KIT: 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 Chapter: Durable Medical Equipment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Home Exercise Kits

Decision rationale: Per ODG TWC, home exercise kits are recommended as an option where home exercise programs are recommended, and where active self-directed home physical therapy is recommended. I respectfully disagree with the UR physician's denial based upon the lack of the patient's education concerning the use of the exercise kit. Documentation outlining proper and safe use is included with the kit. The request is medically necessary.

ONE (1) LUMBAR HOME EXERCISE REHAB KIT: 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 Chapter: Exercise Equipment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Home Exercise Kits

Decision rationale: Per ODG TWC, home exercise kits are recommended as an option where home exercise programs are recommended, and where active self-directed home physical therapy is recommended. I respectfully disagree with the UR physician's denial based upon the lack of the patient's education concerning the use of the exercise kit. Documentation outlining proper and safe use is included with the kit. The request is medically necessary.

SOLACE MULTI-STIM UNIT WITH SUPPLIES, FIVE (5) MONTH RENTAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

Decision rationale: A web search was unable to yield information about the types of electrotherapy provided by this device. There is not enough information to establish medical necessity. MTUS Chronic Pain Medical Treatment Guidelines do not recommend TENS as a primary treatment modality, but support consideration of a one-month home-based TENS trial used as an adjunct to a program of evidence-based functional restoration. Furthermore, criteria for the use of TENS includes pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a documented one-month trial period stating how often the unit was used, as well as outcomes in terms of pain relief and function. The documentation did not include mention of a TENS trial nor that the patient is in a functional restoration program. The request is not medically necessary.