

Case Number:	CM13-0064813		
Date Assigned:	01/03/2014	Date of Injury:	01/19/2013
Decision Date:	05/12/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	12/12/2013

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 and Pain Management and is licensed to practice in Florida. 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 66-year-old male who reported an injury on 01/19/2013 after he missed a step, walking down a flight of stairs which reportedly caused a twisting injury to the bilateral knees. The injured worker underwent an MRI in 05/2013 that documented there was mild effusion and slight prepatellar soft tissue swelling with no evidence of a definitive lateral or medial meniscus tear. The injured worker's treatment history included physical therapy, medications, and rest. The injured worker was evaluated on 09/25/2013 and it was documented that the injured worker complained of low back pain radiating into the bilateral lower extremities rated at a 6/10. Knee pain complaints were rated at a 6/10 also. Physical exam findings included positive medial and lateral stability with a positive Lachman's test of the bilateral knees and restricted range of motion secondary to pain. The injured worker had a positive McMurray's sign to the right knee and a positive anterior/posterior drawer test to the left knee. The injured worker's diagnoses included left patella instability, right meniscus internal derangement. The injured worker's treatment plan included epidural steroid injection to the lumbar spine, arthroscopy of the left knee, and acupuncture. The request for authorization form dated 11/15/2013 documented that surgery was scheduled for the injured worker on 11/15/2013 and a request was made for a postoperative cold therapy unit and SS4 electrical stimulation unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT - PURCHASE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC KNEE PROCEDURE SUMMARY: 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 AND LEG CHAPTER, CONTINUOUS FLOW CRYOTHERAPY

Decision rationale: California Medical Treatment Utilization Schedule does not address continuous flow cryotherapy. Official Disability Guidelines recommend continuous flow cold therapy for up to 7 days in the management of postsurgical pain. The clinical documentation does indicate that the injured worker is scheduled for surgical intervention. However, there are no exceptional factors noted within the documentation to support extending treatment beyond 7 days to require purchase of this equipment. As such, the requested cold physical therapy unit for purchase is not medically necessary or appropriate.

SS4 ELECTRICAL STIMULATION UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC KNEE AND LEG PROCEDURE SUMMARY: NEUROMUSCULAR ELECTRICAL STIMULATION (NMES DEVICES).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS), GALVANIC STIMULATION, AND NEUROMUSCULAR ELECTRICAL STI.

Decision rationale: The requested medical equipment is an electrical stimulation device that contains a neuromuscular electro-stimulation module, interferential current therapy module, and a galvanic stimulation module. The California Medical Treatment Utilization Schedule does recommend a trial of an interferential stimulation unit in the postsurgical management of pain. However, it is recommended that this trial be limited to 30 days and provide documentation of functional benefit and pain relief to support any additional usage of this treatment modality. Additionally, the California Medical Treatment Utilization Schedule recommends neuromuscular electrical stimulation in the management of rehabilitation of stroke patients. Additionally, the use of galvanic stimulation is not recommended by California Medical Treatment Utilization Schedule as it is still considered experimental and investigational. As the requested equipment contains components that are not supported by guideline recommendations, the equipment itself would not be supported. As such, the requested SS4 electrical stimulation unit is not medically necessary or appropriate.