

Case Number:	CM13-0065180		
Date Assigned:	01/03/2014	Date of Injury:	12/12/2009
Decision Date:	06/23/2014	UR Denial Date:	11/22/2013
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 Orthopedic Surgery 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 patient is a 49-year-old male who has filed a claim for internal derangement of the knee associated with an industrial injury date of December 12, 2009. Review of progress notes showed that patient complained of right knee pain with locking of the knee. Findings in the right knee include tenderness over the medial joint space and over the lateral side of the patella. Patellar compression test causes accentuated pain. There is slight decreased range of motion. MRI of the right knee, dated October 15, 2013, showed minimal lateral meniscal tear extending through the superior surfaces of the body and posterior horn. Treatment to date has included NSAIDs, opioids, extensive physical therapy and chiropractic therapy to the left knee, cortisone injections and Orthovisc injections to the left knee, and bracing. Patient had a total of four left knee surgeries, followed by post-operative physical therapy. Utilization review from November 22, 2013 denied the request for post-op acupuncture 2x6 as there is no indication or need for post-op acupuncture for the right knee; IFC unit as there is lack of clinical efficacy with this type of DME; micro cool unit as it has little efficacy and advantage over simple ice or gel packs; home exercise kit as the patient will be having post-operative physical therapy; post-op knee brace as the patient has stable knee; CPM machine as it is not recommended; and tramadol 50mg #60 as there is already authorization for Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST OP ACCUPUNCTURE 2X6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated, as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Furthermore, guidelines state that the time to produce functional improvement is 3 - 6 treatments. In this case, the patient is authorized to undergo right knee arthroscopic surgery with post-operative physical therapy. However, the initial quantity of acupuncture sessions exceeds guideline recommendations. The body part to be treated is likewise not specified. Therefore, the request for post-op acupuncture 2x6 was not medically necessary per the guideline recommendations of CA MTUS.

IFC UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Electrotherapies

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 118-120.

Decision rationale: Pages 118-120 of CA MTUS Chronic Pain Medical Treatment Guidelines state that a one-month trial of the IF unit may be appropriate when pain is ineffectively controlled with medications, in the presence of significant pain from postoperative conditions limiting the ability to perform exercise programs, or if the condition is unresponsive to conservative measures. In this case, the patient has authorization for right knee arthroscopic surgery and post-operative physical therapy sessions. The abovementioned criteria for an IF unit have not been met. Furthermore, the request failed to specify the duration of use, and if the device is for rental or purchase. Therefore, the request for IFC unit was not medically necessary per the guideline recommendations of CA MTUS.

MICRO COOL 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) Knee

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 chapter, Continuous-flow cryotherapy

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. ODG states that continuous-flow cryotherapy 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 this case, patient is authorized to undergo right knee arthroscopy with arthroscopic surgery to include meniscectomy, chondroplasty, synovectomy, and possible lateral release of the patella. This treatment modality may help the patient during the post-operative course for 7 days. However, there is no indication as to the duration of use of this equipment, or whether this request is for rental or purchase. Therefore, the request, as submitted, for a micro cool unit is not medically necessary at this time.

HOME EXERCISE KIT: 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), Knee

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, Home exercise kits.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, home exercise kits are recommended where active self-directed home physical therapy will be performed. However, this patient is already authorized for post-operative physical therapy sessions. Home exercise kits are not necessary in this patient at this time. Therefore, the request for home exercise kit was not medically necessary per the guideline recommendations of ODG.

POST OP KNEE BRACE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHAPTER 13, PAGE 340

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, Knee brace.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, criteria for use prefabricated knee braces include knee instability, ligament insufficiency, reconstructed ligament, articular defect repair, meniscal cartilage repair, painful failed total knee arthroplasty, and painful unicompartmental osteoarthritis. In this case, the patient is authorized to undergo right knee arthroscopy with arthroscopic surgery to include meniscectomy, chondroplasty, synovectomy, and possible lateral release of the patella. The patient did not meet the abovementioned criteria to support the necessity of a knee brace. Therefore, the request for post-op knee brace was not medically necessary per the guideline recommendations of ODG.

CPM MACHINE: 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) Knee and Leg chapter, Continuous passive motion (CPM)

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 passive motion (CPM)

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, criteria for the use of continuous passive motion devices for up to 21 days include total knee arthroplasty, anterior cruciate ligament reconstruction, and open reduction and internal fixation of tibial plateau. In this case, the patient is to undergo arthroscopic surgery, which includes meniscectomy, chondroplasty, synovectomy, and possible lateral release of the patella. There is no clear indication for the necessity of this modality, as patient does not meet the abovementioned criteria. Furthermore, there is no indication as to the duration of use of this equipment. Therefore, the request for CPM machine was not medically necessary per the guideline recommendations of ODG.

TRAMADOL 50 MG # 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOID'S, 119

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 76-81.

Decision rationale: According to pages 76-81 of CA MTUS Chronic Pain Medical Treatment Guidelines, a therapeutic trial of opioids is recommended in cases where non-opioid analgesics have failed, goals of therapy have been set, baseline pain and functional assessments have been made, likelihood of improvement is present, and likelihood of abuse or adverse outcome is absent. There is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, there is already authorization of Norco for post-operative use. There is no clear indication as to why two opioid medications are necessary at this time. Therefore, the request for tramadol 50mg #60 was not medically necessary per the guideline recommendations of CA MTUS.