

Case Number:	CM14-0004196		
Date Assigned:	01/22/2014	Date of Injury:	10/02/2008
Decision Date:	03/25/2014	UR Denial Date:	12/20/2013
Priority:	Standard	Application Received:	01/09/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in Texas. 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 physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records: The patient is a 40-year-old male who reported an injury on 10/02/2008 due to a twisting motion that reportedly caused injury to his right knee and low back. The patient's chronic pain was managed with physical therapy and medications. The patient's most recent clinical documentation indicated that the patient had intermittent knee pain rated as a 7/10. Physical findings of the left knee included range of motion described as 155 degrees in flexion with tenderness along the medial and lateral joint lines, with a positive Lachman's test, positive anterior drawer test, and positive McMurray's test bilaterally. The patient's diagnoses included right knee degenerative change, right knee internal derangement, and right knee osteoarthritis. The patient's treatment recommendations included right total knee replacement surgery. A request was made for a TENS unit, hinged knee brace, and hot/cold wrap

IMR ISSUES, DECISIONS AND RATIONALES

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

THE REQUEST FOR HINGED KNEE BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 1021-1022.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 341-343.

Decision rationale: The requested hinged knee brace is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do not recommend prophylactic bracing or prolonged bracing for ACL-deficient knees. However, the clinical documentation submitted for review does indicate that a recommendation has been made for a total knee replacement. Official Disability Guidelines do recommend a hinged brace in the postsurgical management of a total knee replacement. However, the clinical documentation does not clearly indicate whether authorization for the surgical intervention has been approved or not. Therefore, the need for a hinged knee brace is not clearly established. As such, the requested hinged knee brace is not medically necessary or appropriate

THE REQUEST FOR HOT/COLD WRAP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 10415-1017.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 341-343.

Decision rationale: The requested decision for a hot/cold wrap is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does recommend at-home applications of heat or cold packs to assist with pain control. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to self-directed and self-managed heat and cold application. Therefore, the need for the purchase of specialized durable medical equipment is not clearly established. As such, the requested hot/cold wrap is not medically necessary or appropriate

THE REQUEST FOR TENS UNIT PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS 2009: 9792.24.2 Chronic Pain Medical Treatment Guidelines.

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

Decision rationale: California Medical Treatment Utilization Schedule recommends the use of a TENS unit be based on a 30-day clinical trial. The clinical documentation submitted for review does not provide any evidence that the patient has participated in a 30-day trial that has provided objective functional benefit. The clinical documentation does indicate that the patient has been recommended for a total knee replacement surgery. A 30-day rental is supported in postsurgical management of pain. However, the clinical documentation submitted for review does not clearly indicate that the patient's surgery has been authorized. Therefore, the need for a TENS unit is not clearly established. As such, the requested TENS unit for purchase is not medically necessary or appropriate

