

Case Number:	CM14-0004414		
Date Assigned:	02/05/2014	Date of Injury:	05/31/2010
Decision Date:	06/20/2014	UR Denial Date:	01/10/2014
Priority:	Standard	Application Received:	01/13/2014

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 Orthopaedic 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:

This 44-year-old male sustained an industrial left knee injury on 5/31/10. The mechanism of injury is not documented. A left knee arthroscopy with partial medial meniscectomy, chondroplasty of the medial femoral condyle, partial lateral meniscectomy, patelloplasty, partial synovectomy with removal of loose bodies, and chondroplasty of the femoral groove with intra-articular injection was performed on 10/6/10. The 11/25/13 left knee MR arthrogram findings documented degenerative osteoarthritic changes most severe in the medial compartment, a degenerative tear of the medial meniscus, mild degenerative lateral compartment osteoarthritis, and an oblique tear of the lateral meniscus. The 12/11/13 treating physician report indicated that the patient was doing poorly, with locking and catching of his left knee. He had lateral joint line tenderness. The MRI showed a large lateral meniscus tear of the left knee. The patient has been treated appropriately with physical therapy, injections, medications, and rest, and remains disabled. Recommended treatment included a diagnostic and operative arthroscopy of the left knee with partial lateral meniscectomy, 12 post-operative physical therapy visits, a cold therapy unit, and an electrical stimulation unit. The 1/10/14 utilization review modified the request for a cold therapy unit to 7 days post-operative use. A peer call with the treating physician was documented on 1/10/14 with agreement to modify the request for an electrical stimulation unit to a TENS unit for 30 days post-operative use.

IMR ISSUES, DECISIONS AND RATIONALES

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

DURABLE MEDICAL EQUIPMENT (DME): POST-OPERATIVE COLD THERAPY

UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Integrated Treatment/Disability Duration Guidelines: Knee & Leg (Acute & Chronic) 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, Continuous Flow Cryotherapy.

Decision rationale: Under consideration is a request for a post-operative cold therapy unit. The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines recommend the use of continuous flow cryotherapy as an option after surgery for use up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The 1/10/14 utilization review modified the request for a cold therapy unit and approved post-operative use for 7 days. There is no compelling reason presented to support the medical necessity of continuous flow cryotherapy beyond guideline recommendations. Therefore, this request for a post-operative cold therapy unit is not medically necessary.

DURABLE MEDICAL EQUIPMENT (DME): POST OPERATIVE ELECTRICAL STIM

UNIT: 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, TENS, POST OPERATIVE PAIN (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION), 116

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES PHYSICAL MEDICINE, , 116-117

Decision rationale: Under consideration is a post-operative electrical stimulation unit. The Chronic Pain Medical Treatment Guidelines, for transcutaneous electrotherapy recommend the use of a TENS unit as a treatment option for acute post-operative pain in the first 30 days post-surgery. The 1/10/14 utilization review documented a peer discussion with agreement for modification of the request for an electrical stimulation unit to a TENS unit for 30 days use. There is no compelling reason presented to support the medical necessity of transcutaneous electrotherapy beyond guideline recommendations. Therefore, this request for a post-operative electrical stimulation unit is not medically necessary.