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| Case Number: | CM14-0005300 | | |
| Date Assigned: | 01/24/2014 | Date of Injury: | 06/29/2012 |
| Decision Date: | 06/09/2014 | UR Denial Date: | 12/19/2013 |
| Priority: | Standard | Application Received: | 01/14/2014 |

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 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:

According to the records made available for review, this is a 39-year-old male with a 6/29/12 date of injury. At the time (11/25/13) of the request for authorization for Combo Care 4 electrotherapy, continuous passive motion (CPM) machine, and Thermocool hot and cold contrast therapy with compression, there is documentation of subjective (left knee pain and pain radiating down to his left leg as well as pain in his right knee, complains of right knee giving way) and objective (unable to walk on his heels or tiptoes secondary to pain, decreased sensation in left S1 distribution, medial joint line tenderness to the right knee, McMurray's click is present, and weakness to the right knee extension and flexion) findings, current diagnoses (right knee internal derangement with meniscus tear and left S1 radiculopathy), and treatment to date (physical therapy, activity modification, and medication).

IMR ISSUES, DECISIONS AND RATIONALES

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

COMBO CARE 4 ELECTROTHERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 116-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS - Transcutaneous Electrotherapy Page(s): 116-117.

Decision rationale: The Combo Care 4 unit incorporates interferential, TENS, NMS/EMS and syncopation therapies into one unit. Regarding interferential therapy, MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Regarding TENS, MTUS Chronic Pain Medical Treatment Guidelines identifies TENS unit as an option for acute post-operative pain in the first 30 days post surgery, most effective for mild to moderate thoracotomy pain, and of lesser effect, or not at all, for other surgical procedure. Regarding NMS/EMS, MTUS Chronic Pain Medical Treatment Guidelines states that neuromuscular electrical stimulation (NMES) is not recommended. In addition, MTUS Chronic Pain Medical Treatment Guidelines states that NMES is primarily used as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. Within the medical information available for review, there is documentation of diagnoses of right knee internal derangement with meniscus tear and left S1 radiculopathy. However, there is no documentation of a pending surgical procedure. In addition, guidelines do not support interferential therapy or NMES in the postoperative management of the cited injuries. Therefore, based on guidelines and a review of the evidence, the request for Combo Care 4 electrotherapy is not medically necessary.

CONTINUOUS PASSIVE MOTION (CPM) MACHINE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Continuous Passive Motion (CPM).

Decision rationale: MTUS does not address this issue. ODG identifies documentation of any of the following surgeries [total knee arthroplasty; Anterior cruciate ligament reconstruction; Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint], as criteria necessary to support the medical necessity of a continuous passive motion unit for up to 21 consecutive days. Within the medical information available for review, there is documentation of a diagnosis of osteoarthritis, left knee. However, there is no documentation that any of the following surgeries are pending [total knee arthroplasty; Anterior cruciate ligament reconstruction; Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint]. Therefore, based on guidelines and a review of the evidence, the request for continuous passive motion (CPM) machine is not medically necessary.

THERMOCOOL HOT AND COLD CONTRAST THERAPY WITH COMPRESSION:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg Chapter, Cold/Heat Packs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 338.

Decision rationale: MTUS reference to ACOEM identifies patients' at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Medical Treatment Guideline identifies generally, solely an analgesic effect was demonstrated by the use of continuous cooling; that crushed ice, cold packs and electric-powered cooling devices differ in handling, effect and efficiency; and that the exact recommendations on application time and temperature cannot be given. Therefore, based on guidelines and a review of the evidence, the request for Thermocool hot and cold contrast therapy with compression is not medically necessary.