

Case Number:	CM14-0005314		
Date Assigned:	05/23/2014	Date of Injury:	12/27/2012
Decision Date:	07/30/2014	UR Denial Date:	12/31/2013
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 Occupational Medicine 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 is a 32-year-old female patient with a 12/27/12 date of injury. She injured herself while pulling a pallet with batteries and developed a pain in the left knee and pinch in the lower back. An 11/20/13 progress report indicated that the patient complained of the pain in the lower back and left knee, 8/10. Objective findings revealed tenderness in the paraspinal muscles of the lumbar spine and left knee that did not changed since last visit, with restricted range of motion. There was tenderness over patellar tendon. She commented that physical therapy helped her to decrease pain and tenderness. She was diagnosed with lumbar spine musculoligamentous sprain with radiculopathy, left knee sprain with meniscal tear, partial chondromalacia and tendonitis. Treatment to date: medication management, physical therapy, extracorporeal shockwave therapy to the left knee. There is documentation of a previous 12/31/13 adverse determination, based on the fact that it was not clear why the patient needs these multiple items, and how they were going to supplement the treatment plan.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERFERENTIAL UNIT LEFT KNEE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS) Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2
Page(s): 118-120.

Decision rationale: CA MTUS 9792.24.2. Chronic Pain Medical Treatment Guidelines state that a one-month trial may be appropriate when pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform; exercise programs/physical therapy treatment; or unresponsive to conservative measures. However, there is no clear description of failure of conservative management. There is no documentation of a trial of an IF unit being effective. There is no documentation of significant pain from a post-operative condition causing inability to participate in a home exercise program or substance abuse. In addition, there is no clear documentation of failure of a TENS unit. It is not noted if this request is for a rental or a purchase. Therefore, the request for Interferential Unit Left Knee is not medically necessary.

COLD THERAPY UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296-299.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna(hot&cold unit).

Decision rationale: CA MTUS does not address this issue. 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. However, this patient has not had recent surgery. It is unclear why this patient needs cryotherapy. Guidelines do not support cryotherapy outside of the post-operative setting. Therefore, the request for Cold Therapy Unit is not medically necessary.

LEFT KNEE SLEEVE: 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, compression garment.

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.

Decision rationale: CA MTUS does not address this issue. ODG states that prefabricated knee braces may be appropriate for certain indications, such as knee instability, reconstructed ligament, articular defect repair, or tibial plateau fracture. However, there was no evidence of knee instability, or articular defect repair. In addition, there was a documentation supporting effectiveness of physical therapy to reduce pain and tenderness. There were no references to

support knee sleeve use for patellar tendon tenderness. Therefore, the request for left knee sleeve is not medically necessary.