

<b>Case Number:</b>	CM14-0102832		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	01/18/2011
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 48-year-old female who reported an injury on 01/18/2011. The mechanism of injury was not provided. The injured worker's diagnoses included knee chondromalacia patella, knee tendinitis, and knee meniscus tear. The injured worker's past treatments included cortisone injections, physical therapy, and bracing, with no relief of symptoms, medications, and surgery. The injured worker's diagnostic testing included an unofficial MRI of the left knee on 11/12/2012, unofficial 3 view x-rays of the left knee on 10/10/2013, and an unofficial MRI of the left knee without contrast on 02/10/2014. The injured worker's surgical history included video arthroscopy of the left knee, microfracture procedure, meniscectomy, synovectomy, chondroplasty, removal of loose bodies, and fascial sheath injection on 05/20/2014. In the clinical note dated 05/14/2014, the injured worker complained of left knee pain rated 4/10. The injured worker complained of locking with getting up from a seated position. The injured worker had range of motion to the left knee times 3 of 0 to 130 degrees. The injured worker had intact sensation bilaterally and 5/5 motor strength bilaterally in the knees. The injured worker's medications included tramadol 50 mg 3 times a day as need for pain, meloxicam 7.5 mg twice daily, Norco 10/325 mg every 4 hours as needed, and benazepril 10 mg. The request was for the retrospective purchase of knee stimulator IF unit, electrodes, conductive garment, date of service 05/29/2014. The rationale for the request was not provided. The Request for Authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective purchase of Knee Stimulator IF Unit DOS: 5/29/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Durable Medical Equipment (DME).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS UNIT Page(s): 114-116.

**Decision rationale:** The retrospective request for purchase of Knee Stimulator IF Unit DOS: 5/29/14 is not medically necessary. The injured worker is diagnosed with chondromalacia, patella, tendinitis, and meniscus tear of the knee. The injured worker had left knee arthroscopy surgery on 05/20/2014. The injured worker complains of left knee pain rated 4/10, with complaints of locking when getting up from a seated position. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality, but a 1 month home based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration. The medical records must have documentation of pain of at least 3 months duration, evidence that other appropriate pain modalities, including medication, have been tried and failed, a 1 month trial period of the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Rental would be preferred over purchase during the trial of the TENS unit. Other ongoing pain treatment should also be documented during the trial period, including medication usage, a treatment plan, including the specific short and long term goals of treatment with the TENS unit, should be submitted. The injured worker's medical records lacked documentation of an adjunct program for functional restoration and evidence of tried and failed pain modalities. The requested physician did not provide documentation of an adequate and complete assessment of the injured worker's pain for at least 3 months. Additionally, the request does not indicate the application site for which knee the stimulator is to be applied to, the frequency of use, and length of time to be used. Also, there is a lack of documentation of physical therapy sessions to have been completed to include efficacy of objective functional deficits and improved pain. As such, the retrospective request for purchase of Knee Stimulator IF Unit DOS: 5/29/14 is not medically

**Retrospective Electrodes DOS: 5/29/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Durable Medical Equipment (DME).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS UNIT Page(s): 114-116.

**Decision rationale:** Due to the primary request being not medically necessary, the retrospective request for Electrodes DOS: 5/29/14 is also not medically necessary.

**Retrospective Conductive Garment DOS: 5/29/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Durable Medical Equipment (DME).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS UNIT Page(s): 114-116.

**Decision rationale:** The retrospective request for Conductive Garment DOS: 5/29/14 is not medically necessary. Due to the primary request of knee stimulator being deemed not medically necessary, the retrospective request for Conductive Garment DOS: 5/29/14 is also not medically necessary.