

<b>Case Number:</b>	CM14-0105878		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	01/24/2001
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2014

### 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 Internal Medicine, has a subspecialty in Pulmonary Disease 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:

The injured worker is a 56-year-old male who reported an injury on 01/24/2001 due to a lifting injury. On 05/15/2014, the injured worker presented with left knee pain. The injured worker's surgical history included a left knee surgery in 1991. Upon examination, the injured worker had an antalgic gait favoring the left leg with a slight atrophy of the quadriceps and calf muscles of the left knee. There were 3 arthroscopic portals noted over the left knee secondary to surgery in 2002. The injured worker was unable to squat or duck walk bilaterally. There was positive left sided medial joint line and lateral joint line tenderness. There was positive crepitation and patellar maltracking on the left side. The ranges of motion values were 130 degrees of flexion and 0 degrees of extension. There was 5/5 bilateral motor strength. Prior therapies included physical therapy and medications. Diagnoses were musculoligamentous sprain/strain of the left knee and status post arthroscopic surgery of the left knee. The provider recommended an X-Force stimulator unit, Q-Tech cold therapy recovery system with wrap, and a DVT prevention system. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-Force stimulator unit with supplies and conductive garments x 3 months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation) Criteria for th.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

**Decision rationale:** The request for X-Force stimulator unit with supplies and conductive garments x 3 months is not medically necessary. The California MTUS Guidelines do not recommend an X-Force unit as a primary treatment modality. A 1 month home based trial must be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration. There were also studies that are inconclusive and the published trials do not provide information on stimulation parameters which are most likely to provide optimum pain relief or answer questions about long term effectiveness. There is lack of documentation indicating significant deficits upon physical examination. The efficacy of the injured worker's previous courses of conservative care was not provided. It is unclear if the injured worker underwent an adequate trial. The site at which the X-Force stimulator was indicated for was not provided in the request as submitted. As such, this request is not medically necessary.

**Q Tech cold therapy recovery system with wrap x 21 days:** 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) - Treatment in Workers' Compensation (TWC) Knee and Non-MTUS Official Disability Guidelines (ODG) Treatment Index, 6th Edition (web), 2008 Knee Hand - 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:** The request for Q Tech cold therapy recovery system with wrap X 21 days is not medically necessary. The Official Disability Guidelines (ODG) recommends a Q-Tech cold therapy unit as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. The request for a Q-Tech cold therapy unit for 21 days exceeds the guideline recommendations. The medical documents provided did not indicate the medical need for a cryotherapy unit as that would fall within the guidelines recommendations, such as surgery. Additionally, the site at which a Q-Tech system was indicated for was not provided in the request as submitted. As such, this request is not medically necessary.

**Tech DVT prevention system X 21 days:** 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) - Treatment in Workers' Compensation (TWC) Knee

**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, Compression Garments.

**Decision rationale:** The request for Tech DVT prevention system x 21 days is not medically necessary. The Official Disability Guidelines (ODG) recommends compression garments. There is good evidence for the use of compression if available, but little is known about dosimetry and compression. There is little information known to what level of compression should be applied and for how long. The provider's rationale for Tech DVT prevention system was not provided. The provider's request also does not indicate the site at which the DVT prevention system was indicated for in the request as submitted. As such, this request is not medically necessary.