

Case Number:	CM14-0020158		
Date Assigned:	04/25/2014	Date of Injury:	04/18/1982
Decision Date:	07/07/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/18/2014

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 Texas. 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 55 year old male whose date of injury is 04/18/1982. The mechanism of injury is described as cumulative trauma. The injured worker is status post ACL reconstruction in June of 2012. Note dated 11/21/13 indicates that the injured worker's condition has plateaued and he is considered permanent and stationary. Progress report dated 01/16/14 indicates that the injured worker received a Synvisc injection to the left knee in March 2013, July 2013 and January 2014. On physical examination he has stable Lachman and anterior drawer testing. Range of motion is full. He has positive patellofemoral crepitation, positive grind test and pain with deep squat. Progress report dated 03/13/14 indicates that the injured worker has done conservative physical therapy. He has also done TENS unit therapy at physical therapy with no long-term relief of symptoms. On physical examination the left knee shows stable anterior drawer, stable Lachman and range of motion is 0-130 degrees. No effusion is noted. He does have notable quadriceps atrophy noted to be 1 cm to 2 cm less than the right side. 1 KNEE-HAB UNIT FOR THE LEFT KNEE has been requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 KNEE-HAB UNIT FOR THE LEFT KNEE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-117.

Decision rationale: Based on the clinical information provided, the request for 1 Knee-Hab unit for the left knee is not recommended as medically necessary. The submitted records fail to establish that the injured worker has undergone a successful trial of the unit to establish efficacy of treatment, as required by CA MTUS guidelines. In fact, the submitted records indicate that the injured worker utilized a TENS unit in physical therapy with no long-term relief of symptoms. Additionally, there is no specific, time-limited treatment goals provided as required by CA MTUS guidelines.