

Case Number:	CM14-0031632		
Date Assigned:	06/20/2014	Date of Injury:	01/31/2008
Decision Date:	08/12/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	03/12/2014

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 & Rehabilitation and Pain Management has a subspecialty in Interventional Spine 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 patient is a 67 year old male with an injury date on 01/31/2008. The listed diagnoses per [REDACTED] dated 01/21/2014 are: 1. Cervical chronic sprain/strain with degenerative disc disease and degenerative joint disease. 2. L3 through L5 spinal stenosis and L4-5 instability. 3. Status post right total knee replacement for post traumatic depression. 4. Anxiety. 5. Insomnia. According to this report, the patient complains of more pain in the left knee due to status post of the right knee. The left knee pain is described as intermittent moderate. The patient's current medications are Tramadol, Prilosec, and Xanax. He also uses the topical creams of Ketoprofen, Gabapentin, and Tramadol. Positive straight leg raise test in sitting and lying position was noted. The MRI of the left knee on 01/24/2014 reveals 1. Moderate joint effusion. 2. Chondromalacia patellae. 3. Patellofemoral joint arthropathy. 4. Medial compartment syndrome. 5. Grade III tear in the posterior horn of the medial meniscus. 6. Grade II signal in the anterior and posterior horn of the lateral meniscus. 7. Peripheral tear related to the anterior horn of the lateral meniscus. There were no other significant findings noted on this report. The utilization review denied the request on 02/20/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 01/21/2014 to 02/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of X-force stimulator unit plus 3 months supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation) Page(s): 114-116.

Decision rationale: According to the 01/21/2014 report by [REDACTED] this patient presents with increasing left knee pain. The treater is requesting a purchase of a X-force stimulator unit plus 3 months supplies. X-force stimulator is a combo unit containing TENS and TEJS (joint stimulation). Regarding TENS units, the MTUS guidelines state not recommended as a primary treatment modality, but a one-month home-based unit trial may be considered as a noninvasive conservative option and may be appropriate for neuropathic pain. The guidelines further state a rental would be preferred over purchase during this trial. Review of the medical records from 01/21/2014 to 02/18/2014 shows the patient has L3 through L5 spinal stenosis with significant neuropathic pain and appears to be a candidate for a TENS (Transcutaneous Electric Nerve Stimulation) unit trial. However, there is no indication that the patient has trialed a one-month rental to determine whether or not a TENS unit will be beneficial. Furthermore, TEJS, the combo component of X-force stimulator is not discussed in MTUS or the ODG guidelines. There is no evidence that this combo unit is any superior to conventional TENS units. Therefore, the request for Purchase of X-force stimulator unit plus 3 months supplies is not medically necessary and appropriate.

Two Conductive garments: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg Chapter.

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

Decision rationale: According to the 01/21/2014 report by [REDACTED], this patient presents with increasing left knee pain. The treater is requesting a conductive garment x 2 to be used together with X-force stimulator unit. MTUS does not support conductive garments unless documentation is provided that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, such as skin pathology. This patient does not present with any skin condition that requires the use of a conductive skin garment. Therefore, the request for two Conductive garments is not medically necessary and appropriate.

Purchase of solar care heating system: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.aetna.com/cpb/medical/data/500_599/0540.html, Aetna, Clinical Policy Bulletin: Heating Devices.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter (online), Heat Therapy, Infrared therapy (IR).

Decision rationale: According to the 01/21/2014 report by [REDACTED] this patient presents with increasing left knee pain. The treater is requesting a purchase of solar care heating system. Regarding solar care, ODG guidelines of the low back state not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise). Review of the reports, the treater does not discuss the patient's treatment history or a program of evidence-based conservative care (exercise). In this case, the requested is not in accordance with the guidelines. Therefore, the request for Purchase of solar care heating system is not medically necessary and appropriate.

Purchase of portable heat pad: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.aetna.com/cpb/medical/data/500_599/0540.html, Aetna, Clinical Policy Bulletin: Heating Devices.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 156, 157.

Decision rationale: This request for portable heat pad was authorized by the UR letter from 2/20/14. MTUS and ODG do support heat as appropriate modality for treatment of chronic pain conditions such as arthritic knee pain. The uses of portable heat pad unit appear medically reasonable. Therefore, the request for purchase of portable heat pad is medically necessary and appropriate