

Case Number:	CM14-0037121		
Date Assigned:	06/25/2014	Date of Injury:	08/11/1998
Decision Date:	07/25/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/27/2014

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 69-year-old male who reported an injury on 08/11/1998, with the mechanism of injury not cited within the documentation provided. In the clinical note dated 02/10/2014, the injured worker complained of ongoing discomfort in his left knee. It was noted that the injured worker continued to have left knee pain with walking, standing, weight-bearing activity, and walking up and down stairs. It was noted that the injured worker has used an assistive device, and in a store that offered a scooter, the injured worker would utilize this. It was also noted that the injured worker was requesting to be provided with a wheelchair. Prior treatments included Orthovisc injections and pain medications. The injured worker's prescribed medication regimen included ibuprofen and Voltaren gel. The physical examination of the left knee revealed tenderness to palpation of the patellofemoral and medial joint line. It was noted that the injured worker moved slowly and cautiously with an antalgic gait, favoring the left knee. Diagnoses included left knee arthroscopy and advanced degenerative joint disease in the left knee. The treatment plan included a request for repeat Orthovisc injections for the left knee, a request for a TENS unit for home use to see if improvement could be made in the injured worker's pain; along with a 30 day trial of a Meds-4-INF unit with garment to assist in pain control and decreasing muscle spasms. It was noted that, if this was effective and the injured worker was able to reduce his medication use, it would be recommended for long term use. There was also a request for a wheelchair for the injured worker to use for long periods of extended ambulation. The request for authorization for a TENS unit, Meds-04-INF unit with garment (x30 day trial), and a wheelchair was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tens unit, Meds-04- INF unit with garmet (x30 day trial): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation), page(s) 114-116, Interferential current stimulation (ICS), 118-120 Page(s): 114-116, 118-120.

Decision rationale: The request for Tens unit, Meds-04- INF unit with garmet (x30 day trial) is non-certified. The California MTUS Guidelines state that a TENS unit is not recommended as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence based functional restoration. The criteria for the use of TENS include documentation of pain of at least 3 months' duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, other ongoing pain treatments should also be documented during the trial period, including medication usage, and a treatment plan including the specific short and long term goals of treatment with a TENS unit should be submitted. The guidelines address interferential current stimulation as not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, and medications, and limited evidence on those recommended treatments alone. While not recommended as an isolated intervention, criteria of interferential stimulation to be used anyway includes; pain that is ineffectively controlled due to diminished effectiveness of medications; pain that is ineffectively controlled with medications due to side effects; history of substance abuse; significant pain from postoperative conditions that limits the ability to perform exercise/physical therapy treatment, or unresponsiveness to conservative measures (e.g., repositioning, heat/ice, etc). In the clinical notes provided for review, there is a lack of evidence or documentation of the injured worker having failed conservative therapies such as physical therapy or prescribed medications. There is also lack of documentation of the injured worker's pain level status and/or pain medication efficacy or lack thereof. There is also lack of documentation of adjunct therapy to be used in conjunction with the TENS unit or Meds-04-INF unit. Furthermore, for the use of the interferential current stimulation, the guidelines state it is not recommended as an isolated intervention. Therefore, the request for Tens unit, Meds-04- INF unit with garmet (x30 day trial) is not medically necessary and appropriate.

Wheelchar: 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) , (<http://www.odg-twc.com/odgtwc/ankle.htm#Wheelchair>).

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, Wheelchair.

Decision rationale: The request for wheelchair is non-certified. The Official Disability Guidelines (ODG) state that a wheelchair is recommended if the injured worker requires, and will use, a wheelchair to move around in the residence, and it is prescribed by a physician. In the clinical notes provided for review, there is a lack of documentation of the injured worker having difficulties with ambulation within his residence. It is documented that the injured worker used a motorized scooter only at a store. It is also annotated that the injured worker has used an assistive device. However, it is not annotated the efficacy and the duration of the injured worker having to use the assistive device. Furthermore, the request stated that the injured worker is to use the wheelchair only for periods of extended ambulation. Therefore, the request for a wheelchair is not medically necessary and appropriate.