MAXIMUS Federal Services

Case Number:	CM14-0044014		
Date Assigned:	06/16/2014	Date of Injury:	10/29/2009
Decision Date:	08/04/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/07/2014

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, 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 60-year-old male with date of injury of 10/29/2009. The listed diagnoses per [redacted] are: 1. Posttraumatic arthrosis, right knee, status post 4 arthroscopies. 2. Status post left knee arthroscopy on 02/14/2013.The earliest report provided for review by [redacted] is from 04/29/2013. This report indicates the patient "feels much better compared to prior to surgery." The patient's main complaint is pain to his right knee, which is buckling and giving away. Examination revealed valgus alignment to the right knee. There is crepitus over the patellofemoral joint. The medial and lateral joint leg revealed tenderness and weakness to the knee on extension and flexion secondary to pain. The request is for "ThermoCool compression system, ComboCare 4 and continuous passive motion machine for the patient to utilize postsurgically." Utilization review denied the request on 02/21/2014. The Utilization letter from 02/21/2014 indicates that the patient has been authorized for a total knee arthroplasty and surgery, which has been scheduled for 02/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

COMBO CARE4 ELECTROTHERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy(p114)TENS, chronic pain (transcutaneous electrical nerve stimulation)(p114-116)Criteria for the use of TENS: (p116) Page(s): 114-116.

Decision rationale: This patient presents with chronic right knee pain and has a diagnosis of right osteoarthritis. Utilization review indicates the patient has been authorized for a total knee arthroplasty and the surgery has been scheduled for 02/27/2014. The treating physician is requesting ComboCare 4 electrotherapy for postoperative use. Combocare Electrotherapy Unit combines TENS and EMS. Neuromuscular electrical stimulation (NMES devices) under California Medical Treatment Utilization Schedule (MTUS) p121 states it is not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. Per MTUS Guidelines 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality but a one-month home-based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom-limb pain, and multiple scoliosis. In this case, the patient does not meet the criteria for a TENS and NMES is not supported for chronic pain. The requested treatment is not medically necessary.

DURABLE MEDICAL EQUIPMENT :THERMOCOOL/COLD CONTRAST THERAPY/WITH COMPRESSION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cold Shoulder.

Decision rationale: This patient presents with chronic right knee pain and has a diagnosis of right knee osteoarthritis. Utilization review indicates the patient has been authorized for a total knee arthroplasty and the surgery has been scheduled for 02/27/2014. The treater is requesting ThermoCool cold contrast therapy with compression for postoperative use. The California Medical Treatment Utilization Schedule (MTUS) and ACOEM guidelines do not discuss cold therapy units. Therefore, ODG Guidelines are referenced. Official Disability Guidelines (ODG) Guidelines has the following regarding continuous-flow cryotherapy: Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated. The MTUS Guideline recommends the duration of postoperative use of continuous-flow cryotherapy to be 7 days. The use of the cold therapy unit outside of the postoperative 7 days is not medically necessary, and given there are no discussions on the duration of use, the requested treatment is not medically necessary.

CONTINUOUS PASSIVE MOTION (CPM) MACHINE X30 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ODG guidelines has the following regarding the use of CPM for knee condition.

Decision rationale: This patient presents with chronic right knee pain and has a diagnosis of right knee osteoarthritis. Utilization review indicates the patient has been authorized for a total knee arthroplasty and the surgery has been scheduled for 02/27/2014. The treater is requesting a Continuous passive motion machine for 30 days for post operative use. The California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) guidelines do not discuss continuous passive motion devices. Therefore, Official Disability Guidelines (ODG) guidelines were consulted. ODG under its knee and leg chapter has the following regarding continuous passive motion devices, Recommended as indicated below, for in-hospital use, or for home use in patients at risk of a stiff knee, based on demonstrated compliance and measured improvements, but the beneficial effects over regular PT may be small. Routine home use of CPM has minimal benefit. Although research suggests that CPM should be implemented in the first rehabilitation phase after surgery, there is substantial debate about the duration of each session and the total period of CPM application. ODG further states the criteria for home use is up to 17 days after surgery while patients at risk for a stiff knee are immobile or unable to bear weight. In this case, ODG guidelines have specific timeframes for post operative use for up to 17days after surgery. The requested 30 days is not medically necessary.