

Case Number:	CM14-0046779		
Date Assigned:	08/04/2014	Date of Injury:	10/25/2013
Decision Date:	09/10/2014	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	04/14/2014

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 Occupational Medicine 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 57-year-old male who has submitted a claim for left knee internal derangement and right elbow sprain/strain, medial epicondylitis rule out cubital tunnel syndrome associated with an industrial injury date of 10/25/2013. Medical records from 10/25/2013 to 03/28/2014 were reviewed and showed that patient complained of pain on the medial aspect of the left knee graded 6/10. Physical examination of the left knee revealed tenderness over the medial joint line. Limited left knee flexion was noted. McMurray's, compression, and Valgus stress tests were mildly positive. Negative anterior drawer's sign was noted. MMT, DTR, and sensation to light touch were intact. MRI of the left knee dated 01/15/2014 revealed medial meniscal tear, medial collateral ligament (MCL) sprain, bone contusion medial femoral condyle, and medial compartment chondromalacia. X-ray of the left knee dated 11/04/2013 was unremarkable. Treatment to date has included physical therapy, hinged knee brace, ice application, and pain medications. Utilization review dated 03/28/2014 modified the request for Transcutaneous Electrical Nerve Stimulation (TENS) unit to TENS unit home-trial 30 days for postoperative use because there was no documentation of previous TENS trial. Utilization review dated 03/28/2014 modified the request for Hot/Cold contrast unit to seven day rental of a generic continuous cryotherapy unit without hot therapy or compression because there was no documentation that use of the device will be limited to seven days post-operatively. Also, rationale for need hot of hot therapy was not provided. Utilization review dated 03/28/2014 denied the request for post-operative knee brace because there was no documentation of any condition for which knee brace was documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit, QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114.

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

Decision rationale: According to CA MTUS Chronic Pain Treatment Guidelines, TENS is not recommended as a primary treatment modality. A trial of one-month home-based TENS may be considered as a noninvasive conservative option. It should be used as an adjunct to a program of evidence-based functional restoration. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. In this case, there was no documentation of previous one-month TENS unit trial, which is recommended by the guidelines prior to approval of a TENS unit request. Moreover, the patient was not documented to be actively participating in a functional restoration program. TENS is not recommended as a solitary form of treatment per guidelines recommendation. The request likewise failed to specify the body part to be treated. Therefore, the request for a TENS unit, QTY: 1.00 is not medically necessary.

Hot/Cold contrast unit, QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, knee.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Aetna was used instead. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. In this case, there was no discussion as to why standard ice bags/packs will be sufficient to provide symptomatic relief. The request likewise failed to specify the body part to be treated. Therefore, the request for Hot/Cold Unit, QTY: 1.00 is not medically necessary.

Post operative knee brace: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, BlueCross BlueShield, 2004.

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, Knee brace.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) was used instead. According to ODG, criteria for use prefabricated knee braces include knee instability, ligament insufficiency/deficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental osteoarthritis, and tibial plateau fracture. Custom fabricated knee braces may be used in patients with abnormal limb contour, skin changes, severe osteoarthritis, maximal off-loading of painful or repaired knee compartment, or severe instability. In this case, patient was scheduled to undergo left knee arthroscopy and medial meniscectomy. Utilization review from 03/18/2014 certified the surgical procedure. Guideline criteria were met. Therefore, the request for postoperative knee brace is medically necessary.