

Case Number:	CM14-0062227		
Date Assigned:	07/11/2014	Date of Injury:	11/08/2013
Decision Date:	09/15/2014	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	05/05/2014

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 45-year-old male who reported an injury on 11/08/2013 caused by an unspecified mechanism. The injured worker's treatment history included medications, surgery, and physical therapy. The injured worker was evaluated on 03/25/2014 and it was documented that the injured worker complained of moderate right leg pain. Physical examination of the knee revealed the injured worker walked with a limp. His leg does not fully straighten as he walks. He had about 5 degrees flexion contracture. There was tenderness to palpation on his punctures. There was a grade 2 soft crepitus in his patella. His quadriceps was very weak with atrophy of about 3 cm. Extension on the right was 5 to 100. Diagnoses included right knee medial meniscus tear, causing a locked knee; anxiety; insomnia; obesity; resolved hematoma of the right calf; resolved sprain/strain of the right thigh; status post right subtotal medial meniscectomy; and chondroplasty of the patella. Medications included Ibuprofen; Prilosec; Gabapentin; and topical creams and Tramadol. The request was not submitted for this review. However, the rationale for the home electrical muscle stimulator unit for the left knee was for the injured worker could hardly extend his knee against gravity.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME ELECTRICAL MUSCLE STIMULATOR UNIT FOR LEFT TKNEE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): Page 114-116.

Decision rationale: The requested home electrical muscle stimulator unit for left knee is not medically necessary. Chronic Pain Medical Treatment Guidelines do not recommend a TENS unit as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration and other ongoing pain treatment including medication usage. It also states that the TENS unit is recommended for neuropathic pain including diabetic neuropathy and post-herpetic neuralgia. The guidelines recommends as a treatment option for acute post-operative pain in the first thirty days post-surgery. In addition, the provider failed to indicate long-term functional goals for the injured worker. In addition, the guidelines recommend 30-day trial the recommended the request failed to indicate duration of trial home use for the injured worker. Given the above, the request for home electrical muscle stimulator unit for left knee is not medically necessary.