MAXIMUS Federal Services

Case Number:	CM14-0194937		
Date Assigned:	12/02/2014	Date of Injury:	01/21/2009
Decision Date:	01/16/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	11/20/2014

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 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 55-year old female with date of injury 1/21/09. The treating physician report dated 12/03/14 indicates that the patient presents with pain affecting the right leg. The physical examination findings reveal grossly restricted cervical and lumbar motion to 10 degrees, left shoulder motion to 25%. Further examination reveals asymmetry of the right ankle reflexes, with the right ankle reflex being markedly diminished compared to the left, this is a new finding. It is noted that the patient uses a cane and is able to stand on her heels and toes. Prior treatment history includes a left knee meniscal repair, partial coccyx removal, bilateral breast reduction, umbilical repair with partial abdominalplasty, tubal ligation, bilateral carpal tunnel release, abdominal surgery to repair a urachal cyst, physical therapy, and prescribed medications of Flexeril, Tramadol, Norco, Lorazepam and Prozac. MRI findings of the right knee reveal an oblique tear of the posterior horn of the medial meniscus extending to the undersurface of this structure, a moderate amount of joint effusion was present as well. Patient's work status is TTD. The current diagnoses are: 1. C spine mod DJD C4-C5-C6.2. Carpal tunnel, left worse than right.3. Small partial thickness tear, right shoulder.4. Tendinosis, right shoulder.5. Mild acromioclavicular joint osteoarthritis, bilaterally.6. Tendinopathy, left shoulder.7. Small cyst, left shoulder.8. Moderate bursitis, left shoulder.9. L/S disc degeneration.10. Meniscal tear and degenerative joint disease, right knee.11. Large meniscal tear, left knee.12. Degenerative joint disease, left knee.13. Small deep partial thickness cartilage defect, left knee.14. Moderate to large joint effusion with synovitis, left knee.The utilization review report dated 11/20/14 denied the request for Mobile EGS Purchase, Thermacure Pad and Thermacure 30 day rental based on a lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

MOBIL EGS PURCHASE: 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) Knee/Leg, section: Walking Aids

Decision rationale: The patient presents with pain affecting the right leg. The current request is for Mobil EGS Purchase. Mobilegs is a brand name for ergonomic crutches. The requesting treating physician report was not found in the documents provided. The UR report dated 11/20/14 notes a progress report dated 9/11/14 that states the patient had knee pain rated 5/10 with a sense of giving out. The treating physician requests for Mobilegs to assist ambulation. A progress report dated 12/3/14 notes that the patient is already using a cane. MTUS does not address this specific issue. ODG guidelines state the following about walking aids (canes, crutches, braces, orthosis, and walkers), "Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. Frames or wheeled walkers are preferable for patients with bilateral disease. In this case the patient was already using a cane and there was no documentation provided to support the need for an additional aid. Recommendation is for denial as this request is not medically necessary.

THERMACURE PAD: Overturned

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) Knee/Leg: Heat

Decision rationale: The patient presents with pain affecting the right leg. The current request is for a Thermacure Pad. A Thermacure Pad is a moist digital heating pad. The requesting treating physician report was not found in the documents provided. The UR report dated 11/20/14 notes a prescription for Thermacure-contrast compression therapy and Thermacure pad purchase dated 10/20/14. The MTUS does not address this specific issue. The ODG guidelines state that heat therapy is recommended as an option. In this case the treating physician report requesting the Thermacure Pad is not provided. The ODG guidelines support the current request and the Thermacure Pad is medically necessary.

THERMACURE 30 DAY RENTAL: 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) Knee/Leg, Sections: Continuous-flow cryotherapy

Decision rationale: The patient presents with pain affecting the right leg. The current request is for a Thermacure 30 day trial. There is a prescription pad from MD Orthopedics that has a check box that is checked for Thermacure-Contrast Compression Therapy (PPO's and Work Comp) dated 10/20/14 and the date of surgery for a right knee meniscus tear is 11/20/14. The requesting treating physician report was not found in the documents provided. A Thermacure-contrast compression unit provides both heat and ice compression therapy. MTUS does not address this specific issue. The ODG guidelines regarding continuous flow cryotherapy states, Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The ODG guidelines support the use of heat but support the use of continuous-flow cryotherapy only after surgery as an option for up to 7 days. The patient's scheduled date of surgery was noted as 11/20/14. In this case the physician is requesting a trial of 30 days which exceeds the ODG guidelines recommendation of 7 days. Recommendation is for denial as the request is not medically necessary.