

Case Number:	CM15-0017305		
Date Assigned:	02/05/2015	Date of Injury:	04/01/2001
Decision Date:	04/01/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/29/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 67 year old female who sustained a work related injury April 1, 2001. Past history included chronic atrial fibrillation, hypertension, and severe degenerative joint disease of the bilateral knees, s/p right total knee replacement, right knee arthroscopy x 3 and left knee x 2, bilateral shoulder arthroscopy and left foot hammertoe surgery. According to hospital records dated January 6, 2015, the injured worker underwent a left total knee arthroplasty on this day and tolerated the procedure well with minimal pain. The treating physician documents January 9, 2015, the injured worker has been cleared for home by physical therapy. She ambulated without difficulty. Follow-up plans included appointments in a week with specialist and primary physician, home health, physical therapy, activity as tolerated and no driving for today. According to utilization review dated January 14, 2015, the request for Post-Operative Brace is non-certified. The request for Mobi-Crutches x 2 is non-certified. The request for V-Pulse Rental for (1) month was modified to V-Pulse Rental for (7) days. The request for KneeHab Purchase was modified to KneeHab rental x (1) month. According to the review physician, guidelines used in the determination process included; California MTUS, ACOEM, and ODG-TWC. There is no detailed review rationale present in the medical record.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: Post operative brace (purchase): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg Chapter, Knee brace.

Decision rationale: This patient is status post left knee total knee arthroplasty on 1/9/15. According to post surgical follow up visit dated 1/9/15, the patient is "doing well following surgery. Pain is well controlled." The current request is for DME: POST OPERATIVE BRACE (PURCHASE). The medical file provided for review includes two progress reports dated 1/6/15 and 1/9/15 and provides no discussions regarding the requests. The Utilization review dated 1/4/15 denied the request, but the rationales for the denials were not included in the decision letter. ACOEM Guidelines page 340 states, "A brace can be used for patellar instability, anterior cruciate ligament ACL tear, or medial collateral ligament MCL instability, although its benefits may be more emotional than medical." ODG Guidelines under the Knee Chapter does recommend knee brace for the following conditions, "Knee instability, ligament insufficient, reconstruction ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unit compartmental OA, or tibial plateau fracture." It further states "Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program." In this case, the patient is status post total knee arthroplasty and the requested knee brace is in accordance with ODG and ACOEM guidelines. This request IS medically necessary.

Mobi crutches x2 (purchase): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines- TWC.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines knee and leg chapter, walking aids (canes, crutches, braces, orthoses, and walkers).

Decision rationale: This patient is status post left knee total knee arthroplasty on 1/9/15. According to post surgical follow up visit dated 1/9/15, the patient is "doing well following surgery. Pain is well controlled." The current request is for MOBI CRUTCHES X2 (PURCHASE). The medical file provided for review includes two progress reports dated 1/6/15 and 1/9/15 and provides no discussions regarding the requests. The Utilization review dated 1/4/15 denied the request, but the rationales for the denials were not included in the decision letter. ODG guidelines knee chapter states the following about walking aids (canes, crutches, braces, orthoses, 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." In this case, given the patient's post-operative condition with immobilized left knee, the use of crutches is in accordance with ODG guidelines. The request IS medically necessary.

DME: V-Pulse 1 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation knee and leg chapter, continuous-flow cryotherapy.

Decision rationale: This patient is status post left knee total knee arthroplasty on 1/9/15. According to post surgical follow up visit dated 1/9/15, the patient is "doing well following surgery. Pain is well controlled." The current request is for DME: V-PLUSE 1 MONTH RENTAL. The medical file provided for review includes two progress reports dated 1/6/15 and 1/9/15 and provides no discussions regarding the requests. The Utilization review dated 1/4/15 denied the request, but the rationales for the denials were not included in the decision letter. The V-pulse is a cold therapy, compression and DVT prophylaxis therapy unit. The MTUS and ACOEM guidelines do not discuss cold therapy units. Therefore, ODG Guidelines are referenced. ODG Guidelines under the knee chapter 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." In this case, the treating physician has recommended a month rental which exceeds what is recommended by MTUS. The MTUS Guideline recommends the duration of postoperative use of continuous-flow cryotherapy to be 7 days. This request IS NOT medically necessary.

KneeHab (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS chronic pain Page(s): 114-121.

Decision rationale: This patient is status post left knee total knee arthroplasty on 1/9/15. According to post surgical follow up visit dated 1/9/15, the patient is "doing well following surgery. Pain is well controlled." The current request is for KNEEHAB (PURCHASE). The medical file provided for review includes two progress reports dated 1/6/15 and 1/9/15 and provides no discussions regarding the requests. The Utilization review dated 1/4/15 denied the request, but the rationales for the denials were not included in the decision letter. The Kneehab XP is a combination NMES and TENS. Per MTUS Guidelines page 116, TENS unit have no

proven efficacy in treating chronic pain and is not recommended as a primary treatment modality, but a 1-month home-based trial may be considered for specific diagnoses of neuropathy, CRPS, spasticity, phantom limb pain, and multiple sclerosis. For interferential current stimulation, the MTUS Guidelines page 118 to 120 states it is 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 medication and limited evidence of improvement on those recommended treatments alone." Under NMES devices, the MTUS Guidelines page 121 states it is not recommended. "NMES is used primarily as a part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain." In this case, this patient does not meet any of the indications for both the TENS and NMES, therefore this request IS NOT medically necessary.