

Case Number:	CM15-0144217		
Date Assigned:	08/05/2015	Date of Injury:	12/01/2006
Decision Date:	09/09/2015	UR Denial Date:	06/25/2015
Priority:	Standard	Application Received:	07/24/2015

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:

This injured worker is a 53-year-old male who reported an industrial injury on 12/1/2006. His diagnoses, and or impression, were noted to include lumbar disc disease; lumbosacral flex lesion and disc herniation; cervical degeneration; upper back strain; status-post bilateral knee surgeries. X-rays of the bilateral knees were done on 6-12-2015; with no current imaging studies noted. His treatments were noted to include an agreed medical evaluation on 7-27-2011; diagnostic imaging studies; left knee arthroscopy with meniscectomy chondroplasty and synovectomy on 5-17-2012; right knee arthroscopy in 10-2011; post-operative physical therapy; home H-wave machine - very effective; medication management; and rest from work. The progress notes of 6-12-2015 reported complaints of inflammation, weakness and increased bilateral knee pain, right > left, with an occasional giving-way of the right leg. Objective findings were noted to include joint pain-swelling with decreased right knee range-of-motion; a 20% squatting ability on the right; positive bilateral patellar tenderness with positive left patellar crepitus; positive right McMurray's sign; a right knee varus deformity; and a limped gait. The physician's requests for treatments were noted to include an unloading brace for the left knee, Bio-freeze, and an H-wave machine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unloading brace for left knee: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic).

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 (Acute & Chronic) Chapter under Knee Brace.

Decision rationale: Based on the 06/12/15 progress report provided by treating physician, the patient presents with bilateral knee pain, right worse than left. The patient is status post right knee arthroscopy in October 2011, and left knee arthroscopy with meniscectomy chondroplasty and synovectomy 05/17/12. The request is for UNLOADING BRACE FOR LEFT KNEE. RFA dated 06/12/15 provided. Patient's diagnosis on 06/12/15 included bilateral knee degenerative arthritis of the medial compartment, left knee meniscal tear, right knee torn meniscus, and simple cyst formation at the medial superior arthroscopic portal. The patient has a limping gait. Physical examination to the knees on 06/12/15 revealed mild inflammation, patellar tenderness and decreased range of motion bilaterally. Positive patellar crepitus on the left and positive Varus deformity and McMurray's on the right. Treatment to date has included surgeries, post-operative physical therapy, imaging studies, home H-wave machine, medications, and rest from work. The patient is prescribed Norco and uses Lidoderm patches and Biofreeze. Patient's work status not available. Treatment reports provided from 07/27/11 - 06/12/15. ODG guidelines, Knee & Leg (Acute & Chronic) Chapter under Knee Brace, provides following criteria for the use of knee brace "refabricated knee braces may be appropriate in patients with one of the following conditions: 1. Knee instability; 2. Ligament insufficiency/deficiency; 3. Reconstructed ligament; 4. Articular defect repair; 5. Avascular necrosis; 6. Meniscal cartilage repair; 7. Painful failed total knee arthroplasty; 8. Painful high tibial osteotomy; 9. Painful unicompartmental osteoarthritis; 10. Tibial plateau fracture". Per 06/12/15 progress report, treater states, "I am requesting unloading braces for bilateral knee in order to provide the patient with additional support." Given this patient's consistent intractable knee pain secondary to osteoarthritis of the joint, post-operative status and diagnosis, a brace could provide some pain relief and functional improvement. This request appears reasonable and in accordance with guidelines. Therefore, the request IS medically necessary.

H-wave machine (indefinite use): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Page(s): 117.

Decision rationale: Based on the 06/12/15 progress report provided by treating physician, the patient presents with bilateral knee pain, right worse than left. The patient is status post right knee arthroscopy in October 2011, and left knee arthroscopy with meniscectomy chondroplasty

and synovectomy 05/17/12. The request is for H-WAVE MACHINE (INDEFINITE USE). RFA dated 06/12/15 provided. Patient's diagnosis on 06/12/15 included bilateral knee degenerative arthritis of the medial compartment, left knee meniscal tear, right knee torn meniscus, and simple cyst formation at the medial superior arthroscopic portal. The patient has a limping gait. Physical examination to the knees on 06/12/15 revealed mild inflammation, patellar tenderness and decreased range of motion bilaterally. Positive patellar crepitus on the left and positive Varus deformity and McMurray's on the right. Treatment to date has included surgeries, post-operative physical therapy, imaging studies, home H-wave machine, medications, and rest from work. The patient is prescribed Norco and uses Lidoderm patches and Biofreeze. Patient's work status not available. Treatment reports provided from 07/27/11 - 06/12/15. Per MTUS Guidelines page 117, "H-wave is not recommended as an isolated intervention, but a 1-month home-based trial of H-wave stimulation may be considered as a non-invasive conservative option for diabetic, neuropathic pain, or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration and only following failure of initially recommended conservative care." "And only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS)." MTUS further states trial periods of more than 1 month should be justified by documentations submitted for review. Per 06/12/15 progress report, treater states, "The patient has been using a trial H-wave machine at home, which provides significant pain relief. He reports that he has tried a TENS unit in the past, which provided no benefit. Since the H-wave is beneficial in alleviating the patient's pain, I am requesting an H-wave machine for permanent at home use." However, there is lack of documentation showing objective pain reduction, or reduction in medication use. It appears H-Wave unit was dispensed prior to authorization. This request is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.

Biofreeze: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Biofreeze® cryotherapy gel.

Decision rationale: Based on the 06/12/15 progress report provided by treating physician, the patient presents with bilateral knee pain, right worse than left. The patient is status post right knee arthroscopy in October 2011, and left knee arthroscopy with meniscectomy chondroplasty and synovectomy 05/17/12. The request is for BIOFREEZE. RFA dated 06/12/15 provided. Patient's diagnosis on 06/12/15 included bilateral knee degenerative arthritis of the medial compartment, left knee meniscal tear, right knee torn meniscus, and simple cyst formation at the medial superior arthroscopic portal. The patient has a limping gait. Physical examination to the knees on 06/12/15 revealed mild inflammation, patellar tenderness and decreased range of motion bilaterally. Positive patellar crepitus on the left and positive Varus deformity and McMurray's on the right. Treatment to date has included surgeries, post-operative physical therapy, imaging studies, home H-wave machine, medications, and rest from work. The patient is prescribed Norco and uses Lidoderm patches and Biofreeze. Patient's work status not

available. Treatment reports provided from 07/27/11 - 06/12/15. ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Biofreeze cryotherapy gel: "Recommended as an optional form of cryotherapy for acute pain. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication. This randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group." Per 06/12/15 progress report, treater states "...the patient has had good pain relief with Biofreeze in the past. I am requesting authorization for Biofreeze for additional pain relief." In this case, the patient does not present with acute pain for which Biofreeze would be indicated. The patient presents with chronic pain and treater does not report any flare-up or new injury. The use of menthol for a chronic condition is not supported by guidelines. Therefore, the request IS NOT medically necessary.