MAXIMUS Federal Services

Case Number:	CM15-0160179		
Date Assigned:	08/26/2015	Date of Injury:	04/11/2007
Decision Date:	10/05/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	08/17/2015

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, Oregon, Washington
Certification(s)/Specialty: Orthopedic Surgery

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 56 year old male who sustained an injury on 4-11-07 involving his left thumb, left knee and left ankle. The specific initial symptoms and complaints are not included in the medical records. Diagnostic testing included X-rays and MRI's. Treatment has included knee brace, anti-inflammatory medication, rest and physiotherapy for the ankle and the knee. In addition a surgical report of the left ankle with reconstruction of lateral collateral ligament was performed on 3-24-09. Medications have included Naproxen 500 mg and Tramadol 50 mg. Currently as noted an MRI left knee was performed on 7-16-15 which was reported as: tear of the posterior horn of the medical meniscus, Grade 1 chondromalacia patella and Trace knee effusion. The physical examination reports moderate tenderness to palpation over the anterior and posterior aspects of the lateral malleolus and moderate tenderness to palpation over the tibia talar joint space. The PR2 dated 7-21-15 documents currently the IW has pain in his left ankle that is rated 8-9 out of 10. Medications currently prescribed for the pain are Naproxen and Tramadol. Tramadol was effective in alleviating his pain and discomfort. The examination of the left ankle notes normoactive range of motion with moderate pain and discomfort the end points in dorsiflexion. There is moderate tenderness to palpation over the anterior and posterior aspects of the lateral malleolus and moderate tenderness to palpation over the tibiotalar joint space. Strength was evaluated to be a 5-5 upon dorsiflexion and plantar flexion of the ankle against resistance. Diagnoses include Osteochondral lesion posterolateral talar dome; Tendinosis partial talofibular ligament with suspect partial tear anterior talofibular ligament, Chronic injury changes to the superficial and deep components to the deltoid ligament complex with bony

fragments steep to the deep ligamentous components, Localized foci of bone marrow edema; Degenerative changes of the talonavicular joint with large dorsal spur; Tear posterior horn of the medical meniscus and Grade 1 chondromalacia patella of the left knee. A request for left ankle surgical incision of osteochondral defects of talus with arthroscopy of the left ankle with extensive debridement and tenosynovectomy, chrondroplasty left talus, manipulation of the left ankle and arthrocentesis with intra-articular injection, left ankle. The IW work status includes work with limitations. Current requested treatments Associated Service: Interferential current stimulator (IF), 2 channel; Associated Service: Micro Cool unit with supplies, Associated Service: 2- lead TENS (transcutaneous electrical nerve stimulation) unit with supplies; Associated Service: Home exercise kit and Associated Service: Motorized compression pump at time of surgery and for 4 weeks post op.

IMR ISSUES, DECISIONS AND RATIONALES

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

Postoperative acupuncture to the left ankle, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Per the MTUS Acupuncture Medical Treatment Guidelines, pages 8&9 frequency and duration of acupuncture or acupuncture with electrical stimulation maybe performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(ef). The guidelines specifically report 3-6 treatments initially. As the request is for 12 visits the determination is not medically necessary

Associated Service: MicroCool unit with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 370.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ankle section.

Decision rationale: CA MTUS/ACOEM is silent on the issue of continuous flow cryotherapy. According to the ODG, Ankle section, continuous flow cryotherapy is not recommended. Therefore the request is not medically necessary.

Associated Service: IF (interferential current stimulator), 2 channel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118 and 119.

Decision rationale: Regarding the Interferential Current Stimulation (ICS), the California MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, pages 118-119 state, 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 medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. As there is insufficient medical evidence regarding use in this clinical scenario, the determination is not medically necessary.

Associated Service: 2-lead TENS (transcutaneous electrical nerve stimulation) unit with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post operative pain (transcutaneous electrical nerve stimulation) Page(s): 116-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 113 and 114.

Decision rationale: According to the California MTUS Chronic Pain Medical Treatment Guideline regarding TENS, pages 113 and 114, chronic pain (transcutaneous electrical nerve stimulation), not recommended 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, for neuropathic pain and CRPS II and for CRPS I (with basically no literature to support use). Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. 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; rental would be preferred over purchase during this trial. In this case there is insufficient evidence of chronic neuropathic pain from the exam note of 7/21/15 to warrant a TENS unit. Therefore the request is not medically necessary.

Associated Service: Home exercise kit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-338.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46 and 47.

Decision rationale: CA MTUS/Chronic Pain Medical Treatment Guidelines, Exercise page 46 and 47 state the exercise is recommended. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. As the guidelines do not recommend any particular exercise program, there is lack of medical necessity for a home exercise kit. Therefore the request is not medically necessary.

Associated Service: Motorized compression pump at time of surgery and for 4 weeks post-op: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Knee and Leg Chapter, Compression Garments.

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 section.

Decision rationale: CA MTUS/ACOEM is silent on the issue of DVT compression garments. The ODG, Knee and Leg section, Compression Garments, summarizes the recommendations of the American College of Chest Physicians and American Academy of Orthopedic Surgeons. It is recommend use of mechanical compression devices after all major knee surgeries including total hip and total knee replacements. In this patient there is no documentation of a history of increased risk of DVT or major knee surgery. The patient underwent a routine knee arthroscopy. Therefore medical necessity cannot be established and therefore the determinations for non-certification for the requested device. The use of an outpatient pneumatic compression device is not medically necessary as it is not in accordance with nationally accepted standards of medical practice. While the use of a pneumatic compression device is clinically appropriate in an inpatient setting, their utility has not been demonstrated in an outpatient setting once the postoperative total knee arthroplasty patient is ambulatory. There are recommendations from the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (9th edition) that discuss the prevention of venous thromboembolism in orthopedic surgery patients. One of the recommendations is: "In patients undergoing total hip arthroplasty (THA) or total knee arthroplasty (TKA), we recommend use of one of the following for a minimum of 10 to 14 days rather than no antithrombotic prophylaxis: low-molecular-weight heparin (LMWH), fondaparinux, apixaban, dabigatran, rivaroxaban, low-dose unfractionated heparin (LDUH), adjusted-dose vitamin K antagonist (VKA), aspirin (all Grade 1B), or an intermittent pneumatic compression device (IPCD) (Grade 1C)." There is nothing in the medical record that documents that this patient is intolerant or has a contraindication to: low-molecular-weight heparin, low-dose unfractionated heparin, or adjusted-dose vitamin K antagonist. An additional recommendation from the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (9th edition) is that: "In patients undergoing major orthopedic surgery, we suggest using dual prophylaxis with an antithrombotic agent and an IPCD during the hospital stay (Grade 2C)." This recommendation states that the use of an intermittent pneumatic

compression device is only indicated in the inpatient setting and is not recommended in the outpatient setting once the patient is ambulatory. The American Academy of Orthopaedic Surgeons has also released their guidelines for deep venous thrombosis prophylaxis in arthroplasty patients. The AAOS has stated: "In the absence of reliable evidence, it is the opinion of this work group that patients undergoing elective hip or knee arthroplasty, and who also have a known bleeding disorder (e.g., hemophilia) and/or active liver disease, use mechanical compressive devices for preventing venous thromboembolism." There is no evidence on the medical record that this patient has a known bleeding disorder and/or active liver disease. Therefore this request is not medically necessary.