

Case Number:	CM15-0199719		
Date Assigned:	10/14/2015	Date of Injury:	04/08/2005
Decision Date:	12/31/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/12/2015

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, Indiana, Oregon

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 59 year old female, who sustained an industrial-work injury on 4-8-05. She reported initial complaints of right knee pain. The injured worker was diagnosed as having carpal tunnel syndrome, synovitis and tenosynovitis, disturbance of skin sensation, and other fibromatoses of muscle, ligament, and fascia. Treatment to date has included medication, knee brace (no benefit), surgery (carpal tunnel), and diagnostics. MRI results were reported on 4-10-15 a complex horizontal tear, lateral meniscus, hypoplastic body, medial meniscus, no significant chondromalacia of the patella. Currently, the injured worker complains of Meds include Voltaren gel, Elavil, and Amitriptyline. Per the primary physician's progress report (PR-2) on 9-21-15, exam noted right knee hinged wrap around knee brace in place, exquisite tenderness over the posterior horn of the lateral meniscus, slight laxity at the lateral collateral ligament with pain, positive McMurray's test for click and mild pain, and reverse McMurray's is positive indicating tear in the lateral meniscus is unstable and has not improved with conservative care. Current plan of care includes surgery to the right knee. The Request for Authorization requested service to include postoperatively physiotherapy visits, 2 x 6, associated surgical service: Micro cool, IFC unit and supplies, transcutaneous electrical nerve stimulation (TENS) unit-supplies, exercise kit, and motorized compression pump with stockings. The Utilization Review on 10-9-15 modified the request for postoperatively physiotherapy visits, 2 x 3, and denied the request for associated surgical service: Micro cool, IFC unit and supplies, transcutaneous electrical nerve stimulation (TENS) unit-supplies, exercise kit, and motorized

compression pump with stockings, per CA MTUS (California Medical Treatment Utilization Schedule) Guidelines; Post-surgical Treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Postoperatively physiotherapy visits, 2 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Knee.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Knee.

Decision rationale: According to the CA MTUS/Post Surgical Treatment Guidelines, Knee Meniscectomy, page 24, 12 visits of therapy are recommended after arthroscopy with partial meniscectomy over a 12-week period. The guidelines recommend initially of the 12 visits to be performed. As the request exceeds the initial allowable visits, the request is not medically necessary.

Associated surgical service: Micro cool: 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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of knee cryotherapy. According to ODG Knee Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore the request is not medically necessary.

Associated surgical service: IFC unit and supplies: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines, Galvanic Stimulation, page 117 and Interferential Current Stimulation, page 118, provide the following discussion regarding the forms of electrical stimulation contained in the SurgStim 4: Galvanic stimulation is not recommended by the guidelines for any indication. In addition interferential

current stimulation is not recommended as an isolated intervention. Therefore the IFC unit is not recommended by the applicable guidelines and is therefore not medically necessary.

Associated surgical service: TENS unit/supplies: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: According to the California MTUS Chronic Pain Medical Treatment Guideline regarding TENS, pages 113-114, 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 notes to warrant a TENS unit. Therefore the determination is not medically necessary.

Associated surgical service: Exercise kit: 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.

Decision rationale: CAMTUS/ACOEM is silent on the use of home exercise kits. ODG shoulder and knee are referenced. These kits are recommended as they are a low cost way of significantly improving clinical outcomes. As the surgery is approved, the request for the home exercise kit is medically necessary.

Associated surgical service: Motorized compression pump with stockings: 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.

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 to 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 is planned for a routine knee arthroscopy. Therefore the request is not medically necessary.