

<b>Case Number:</b>	CM15-0205129		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	03/24/2015
<b>Decision Date:</b>	12/14/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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: Maryland, Virginia, North Carolina  
 Certification(s)/Specialty: Plastic 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 60-year-old female, who sustained an industrial injury on March 24, 2015. The injured worker was diagnosed as having a large triangular fibrocartilage tear of the right wrist. Treatment and diagnostic studies to date has included magnetic resonance imaging of the wrist, x-rays of the wrist and hand, acupuncture with the quantity unknown, chiropractic therapy with the quantity unknown, physical therapy with the quantity unknown, medication regimen, injections, and use of bracing. In a progress note dated September 17, 2015 the treating physician reports complaints of locking and catching of the right wrist. Examination performed on September 17, 2015 was revealing for tenderness to the right wrist. On September 17, 2015, the treating physician noted magnetic resonance imaging of the right wrist with the date unknown that was revealing for large triangular fibrocartilage tear. In an initial examination performed on July 23, 2015 the treating physician noted swelling and tenderness to the dorsal region of the wrist, clicking and locking at the radioulnar joint, and a decreased grip strength on the right versus the left. On July 23, 2015, the treating physician noted an x-ray to the right hand and wrist with the date unknown that was revealing for soft tissue swelling. On September 30, 2015 the treating physician requested post-operative physical therapy at 3 times weekly for 4 weeks at a total of 12 sessions, cold therapy unit purchase, and a 30 day rental of an interferential frequency unit, but did not indicate the specific reasons for the requested equipment and therapy. On October 08, 2015 the Utilization Review determined the requests for post-operative physical therapy at 3 times weekly for 4 weeks at a total of 12 sessions, cold therapy unit purchase, and a 30 day rental of an interferential frequency unit to be not medically necessary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative physical therapy, 3 times weekly for 4 weeks, 12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

**Decision rationale:** According to the MTUS Postsurgical Treatment Guidelines, the postsurgical treatment for TFCC injuries-debridement (arthroscopic) is 10 visits over 10 weeks with a postsurgical physical medicine treatment period of 4-months. An initial course of therapy should be completed first, which means one-half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth. Therefore, based on these guidelines, 12 visits would exceed the initial course of therapy guidelines and should not be considered medically necessary.

**Associated Surgical Services: Cold therapy unit, purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg - Continuous flow cryotherapy.

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

**Decision rationale:** According to the Official Disability Guidelines, continuous-flow cryotherapy is 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 usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting. His meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of knee surgery. There is limited information to support active vs.

passive cryo units. Aetna considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. This study concluded that continuous cold therapy devices, compared to simple icing, resulted in much better nighttime pain control and improved quality of life in the early period following routine knee arthroscopy. Two additional RCTs provide support for use after total knee arthroplasty (TKA). Cold compression reduced blood loss by 32% and pain medication intake by 24%. It improved ROM and reduced hospital stay by 21%. The purchase of a cold therapy unit is not consistent with a 7-day use and thus, should not be considered medically necessary.

**Associated Surgical Services: IF (interferential frequency) unit, 30 day rental: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** According to the Chronic Pain Medical Treatment guidelines, interferential current stimulation (ICS) 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 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-interpretible for recommendation due to poor study design and/or methodologic issues. In addition, although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Two recent randomized double-blind controlled trials suggested that ICS and horizontal therapy (HT) were effective in alleviating pain and disability in patients with chronic low back pain compared to placebo at 14 weeks, but not at 2 weeks. The placebo effect was remarkable at the beginning of the treatment but it tended to vanish within a couple of weeks. The studies suggested that their main limitation was the heterogeneity of the low back pain subjects, with the interventions performing much better for back pain due to previous multiple vertebral osteoporotic fractures, and further studies are necessary to determine effectiveness in low back pain from other causes. A recent industry-sponsored study in the Knee Chapter concluded that interferential current therapy plus patterned muscle stimulation (using the RS-4i Stimulator) has the potential to be a more effective treatment modality than conventional low-current TENS for osteoarthritis of the knee. This recent RCT found that either electroacupuncture or interferential electrotherapy, in combination with shoulder exercises, is equally effective in treating frozen shoulder patients. It should be noted that this study only showed the combined treatment effects with exercise as compared to no treatment, so the entire positive effect could have been due to the use of exercise alone. While not recommended as an isolated intervention, patient selection criteria if Interferential stimulation is to be used anyway. Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain

is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A jacket should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. Sufficient justification for an IF unit rental has not been provided. The patient would have to have failed typical postoperative pain management or other extenuating circumstances prior to consideration for an IF unit as outlined above. Therefore, it should not be considered medically necessary.