

<b>Case Number:</b>	CM15-0207509		
<b>Date Assigned:</b>	10/26/2015	<b>Date of Injury:</b>	07/08/2015
<b>Decision Date:</b>	12/14/2015	<b>UR Denial Date:</b>	10/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2015

### 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 52 year old male with an industrial injury dated 07-08-2015. A review of the medical records indicates that the injured worker is undergoing treatment for left knee medial meniscus tear, left knee pain and left knee sprain and strain. According to the progress note dated 09-08-2015, the injured worker reported left knee pain rated 7 out of 10 without medications and 4 out of 10 with medications. Pain was aggravated with activities such as kneeling, rising up from sitting, lifting, prolonged sitting, standing, walking, ascending and descending stairs. It was relieved with rest and medication. Objective findings (09-08-2015) revealed muscle weakness to the left knee due to pain, painful range of motion, and tenderness to palpitation of the anterior left knee, lateral left knee, medial left knee and posterior left knee. Treatment has included Magnetic Resonance Imaging (MRI) of left knee dated 08-14-2015, prescribed medications, work restrictions, and periodic follow up visits. The utilization review dated 10-05-2015, non-certified the requests for Interferential unit a 5 month convert to purchase and Hot & cold unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential unit a 5 month convert to purchase: 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): Transcutaneous electrotherapy.

**Decision rationale:** The patient presents with left knee pain. The request is for INTERFERENTIAL UNIT A 5 MONTH CONVERT TO PURCHASE. The request for authorization form is dated 09/08/15. MRI of the left knee, 08/14/15, shows flap tear medial meniscus posterior horn; full-thickness chondral defect weight-bearing surface medial femoral condyle; reticular marrow edema of the lateral tibial plateau may represent osseous contusion; moderate joint effusion. Patient's diagnoses include left knee medial meniscus tear; left knee pain; left knee sprain/strain. Physical examination of the left knee reveals muscle weakness due to the pain. The ranges of motion are decreased and painful. There is tenderness to palpation of the anterior knee, lateral knee, medial knee and posterior knee. Valgus causes pain. Varus causes pain. Apley's Compression causes pain. McMurray's causes pain. Patient's medications include Anaprox, Prilosec, Tramadol, and Cyclobenzaprine. Per progress report dated 10/06/15, the patient to remain off-work. MTUS, Interferential Current Stimulation (ICS) Section, pages 118-120 states, "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." Per progress report dated 09/08/15, treater's reason for the request is "for treatment of sequelae arising from this patient's industrial injuries to decrease pain and decrease the need for oral medication." Review of provided medical records show the patient has not previously trialed an IF Unit. MTUS supports a one-month trial of an IF Unit for treater to study efficacy and show evidence of functional improvement. In this case, however, the request for 5 months exceeds what is allowed by MTUS guidelines. Additionally, treater does not discuss or document patient's pain to be ineffectively controlled with medications due to diminished effectiveness or side effects, history of substance abuse, pain from postoperative conditions, or unresponsive to conservative measures. Therefore, the request IS NOT medically necessary.

**Hot/cold unit:** 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 & Leg Chapter under Continuous-flow cryotherapy.

**Decision rationale:** The patient presents with left knee pain. The request is for HOT/COLD UNIT. The request for authorization form is dated 09/08/15. MRI of the left knee, 08/14/15, shows flap tear medial meniscus posterior horn; full-thickness chondral defect weight-bearing surface medial femoral condyle; reticular marrow edema of the lateral tibial plateau may represent osseous contusion; moderate joint effusion. Patient's diagnoses include left knee medial meniscus tear; left knee pain; left knee sprain/strain. Physical examination of the left knee reveals muscle weakness to the due to pain. The ranges of motion are decreased and painful. There is tenderness to palpation of the anterior knee, lateral knee, medial knee and posterior knee. Valgus causes pain. Varus causes pain. Apley's Compression causes pain. McMurray's causes pain. Patient's medications include Anaprox, Prilosec, Tramadol, and Cyclobenzaprine. Per progress report dated 10/06/15, the patient to remain off-work. ODG Guidelines, Knee & Leg Chapter under Continuous-flow cryotherapy states: 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. Per progress report dated 09/08/15, treater's reason for the request is "for treatment of sequelae arising from this patient's industrial injuries to decrease pain and decrease the need for oral medication." ODG supports the use of Hot/Cold Unit for postoperative recovery for no more than 7 days. However, treater does not discuss or document the patient to be postoperative. Additionally, guidelines do not allow for indefinite or open-ended use of Hot/Cold Units. Therefore, the request IS NOT medically necessary.