

Case Number:	CM15-0221554		
Date Assigned:	11/16/2015	Date of Injury:	03/07/2014
Decision Date:	12/24/2015	UR Denial Date:	10/16/2015
Priority:	Standard	Application Received:	11/11/2015

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 41 year old female, who sustained an industrial injury on 3-7-2014. The medical records indicate that the injured worker is undergoing treatment for left knee sprain-strain and tear of the lateral meniscus of the left knee. According to the progress report dated 8-31-2015, the injured worker presented with complaints of constant pain in her left knee, associated with locking and giving way. The level of pain is not rated. The physical examination of the left knee reveals tenderness to palpation over the medial and lateral joint lines, limited range of motion, and positive McMurray's and Apley's test. The current medications are Ibuprofen and Ketoprofen. Previous diagnostic studies include x-rays and MRI of the left knee. The treating physician describes the MRI as "a bucket-handle tear of the posterior horn of the lateral meniscus". Treatments to date include medication management, physical therapy, and injections. Work status is described as temporarily totally disabled. The treatment plan included left knee arthroscopy. The original utilization review (10-16-2015) had non-certified a request for motorized cold therapy and A-stimulator device for the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized cold therapy for the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Cold Therapy, page 292.

Decision rationale: Review of orthopedic utilization report noted unclear indication if the left knee arthroscopy has been authorized. Regardless, MTUS Guidelines is silent on specific use of motorized cold therapy, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day post-operative period, as efficacy has not been proven after. Submitted reports have not provided clear indication or extenuating circumstances beyond guidelines criteria to support for the motorized cold therapy device for an unspecified duration. The Motorized cold therapy for the left knee is not medically necessary and appropriate.

A-stimulator device for the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg.

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

Decision rationale: Review of orthopedic utilization report noted unclear indication if the left knee arthroscopy has been authorized. Regardless, per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of Stim Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics, physical therapy, and activity modifications/rest, yet the patient has remained symptomatic and functionally impaired. Although, a Stim device may be recommended in the acute post-operative period of 30-days for mild to moderate thoracotomy pain with lesser effect for other orthopedic procedures, there is no documentation on how or what Stim unit is requested, functional improvement from trial treatment, nor is there any documented short-term or long-term goals of treatment with the Stim unit for unspecified duration. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from any Stim treatment already rendered for unspecified duration of use. The A-stimulator device for the left knee is not medically necessary and appropriate.