MAXIMUS Federal Services

Case Number:	CM15-0052252		
Date Assigned:	03/25/2015	Date of Injury:	01/17/2014
Decision Date:	05/12/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	03/19/2015

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: California
Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 30-year-old female who reported an injury on 01/17/2014 due to an unspecified mechanism of injury. On 01/05/2015, she presented for an evaluation regarding her knee symptoms. She reported giving way of her left knee 2 to 3 times a day as well as marked difficulty going down the driveway. She was noted to be using a cane for ambulation. It was noted that the injured worker had undergone an MRI that showed a medial meniscus tear. On examination, she had restricted flexion by about 20 degrees on the left, she lacked terminal 5 degrees to 8 degrees of extension, and could extension the right knee fully with about 5 degrees of hyperextension. She could not extend the left knee to neutral position and had about 5 degrees of flexion. There was exquisite tenderness over the body of the posterior horn of the medial meniscus and significant atrophy of the left thigh. There was also significant quadriceps atrophy secondary to the left knee injury. She was diagnosed with unspecified internal derangement of the left knee, tear of the medial cartilage or meniscus of the left knee, chondromalacia patella and villonodular synovitis of the left leg. It was recommended that she undergo an arthroscopy with arthroscopic surgery for the left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential unit with supplies: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines, this form of treatment is not recommended as an isolated intervention and should be used in conjunction with treatment modalities with a functional restoration approach. It is also stated that a 1 month home based trial may be considered when there is failure of conservative care. The documentation submitted for review does not state a clear rationale for the medical necessity of an interferential unit with supplies to support the request. Also, it was not specified whether this was being requested as a rental or a purchase, and there was no indication that the injured worker had failed recommended treatment modalities or that she had undergone a 1 month home based trial. Without this information, the request would not be supported. As such, the request is not medically necessary.

Micro cool: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 388.

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, Continuous flow cryotherapy.

Decision rationale: According to the Official Disability Guidelines, continuous flow cryotherapy is recommended for up to 7 days postoperatively. The documentation provided and request do not state a duration of use with the requested micro cool unit. There was a lack of documentation regarding whether or not this is being requested as a purchase or a rental. Without this information, the request would not be supported. As such, the request is not medically necessary.

TENS unit with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116 - 117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116-117.

Decision rationale: According to the California MTUS Guidelines, this form of treatment is not recommended as an isolated intervention and should be used in conjunction with treatment modalities with a functional restoration approach. It is also stated that a 1 month home based trial may be considered when there is failure of conservative care. The documentation submitted

for review does not state a clear rationale for the medical necessity of a TENS unit with supplies to support the request. Also, it was not specified whether this was being requested as a rental or a purchase, and there was no indication that the injured worker had failed recommended treatment modalities or that she had undergone a 1 month home based trial. Without this information, the request would not be supported. As such, the request is not medically necessary.

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 Exercise Page(s): 46-47.

Decision rationale: According to the California MTUS Guidelines, exercise is recommended. However, there is no strong evidence to support the recommendation of any particular exercise regimen over any other. The documentation submitted for review fails to show a clear rationale for the medical necessity of a home exercise kit. There was no indication that the injured worker could not perform regular home stretching exercises on his own to support the medical necessity of a home exercise kit. Therefore, the request is not supported. As such, the request is not medically necessary.

Deep vein compression pump with stockings: 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).

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, Compression Garments.

Decision rationale: The Official Disability Guidelines state that compression garments are effective in the prevention of DVT. The injured worker was not noted to be at high risk for developing DVT to support the medical necessity of this request. There was also no clear rationale provided for the medical necessity of its use, and information regarding whether it was being requested as a purchase or rental, and the duration was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

Post-operative physical therapy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: The California Postsurgical Rehabilitation Treatment Guidelines state that an initial course of therapy should be undertaken with half the allotted number of sessions and a re-evaluation to determine treatment success. Assuming that the injured worker's left knee surgery has been approved, postoperative physical therapy would be supported. However, the number of sessions being requested was not stated within the request. Without this information, the request would not be supported by the evidence based guidelines. As such, the request is not medically necessary.

Post-operative acupuncture: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the California Acupuncture Treatment Guidelines, acupuncture may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten the functional recovery. Assuming that the injured worker's surgery has been approved, acupuncture treatment may be supported to use following surgery to hasten the functional recovery. However, the number of sessions being requested was not stated within the request, nor was the body part to receive acupuncture therapy. Without this information, the request would not be supported by the evidence based guidelines. As such, the request is not medically necessary.

Transportation to surgery center: 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) Pain, Transportation.

Decision rationale: According to the Official Disability Guidelines, transportation is recommended for medically necessary transportation to appointments in the same community for those with disabilities preventing them from self transport. The documentation submitted does not indicate that the injured worker has a disability preventing her from self transport to support the medically necessity of this request. There was also no indication that she did not have means of transportation or that she could not use public transportation the surgery center. Without this information, the request would not be supported. As such, the request is not medically necessary.