

Case Number:	CM15-0083862		
Date Assigned:	05/06/2015	Date of Injury:	06/16/1998
Decision Date:	06/04/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	05/01/2015

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: Emergency 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 61 year old female, who sustained an industrial injury on 6/16/1998. The current diagnoses are left knee pain and severe degenerative joint disease of the left knee. According to the progress report dated 8/5/2014, the injured worker complains of left knee pain. She notes that she is unable to tolerate stairs, as she is in a great deal of pain. Her knee continues to buckle. The physical examination of the left knee reveals mild effusion, medial and lateral joint line tenderness to palpation, limits in range of motion secondary to pain, crepitus with range of motion, and mildly antalgic gait. The current medication list was not available for review. Treatment to date has included medication management, X-rays, electrodiagnostic testing, and cortisone injections. Per notes, knee surgery was denied. The plan of care includes TENS unit, cold therapy, and continuous passive motion machine.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit (transcutaneous electrical nerve stimulation) E0730: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic,(transcutaneous electrical nerve stimulation), pages 114 - 116 Page(s): 114-116.

Decision rationale: The requested TENS Unit (transcutaneous electrical nerve stimulation) E0730 is not medically necessary. Chronic Pain Medical Treatment Guidelines, TENS, chronic, (transcutaneous electrical nerve stimulation), pages 114 - 116, note "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". The injured worker has left knee pain. She notes that she is unable to tolerate stairs, as she is in a great deal of pain. Her knee continues to buckle. The physical examination of the left knee reveals mild effusion, medial and lateral joint line tenderness to palpation, limits in range of motion secondary to pain, crepitus with range of motion, and mildly antalgic gait. Knee surgery has been denied. The treating physician has not documented a current rehabilitation program, or objective evidence of functional benefit from electrical stimulation under the supervision of a licensed physical therapist or home use. The criteria noted above not having been met, TENS Unit (transcutaneous electrical nerve stimulation) E0730 is not medically necessary.

Cold Therapy E0218: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 329-360. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg chapter - 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, Shoulder, Continuous Flow Cryotherapy.

Decision rationale: The requested Cold Therapy E021 is not medically necessary. CA MTUS is silent on this issue and Official Disability Guidelines, Shoulder, Continuous Flow Cryotherapy, recommends up to 7 days post-op cold therapy. In a post-operative setting, cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The injured worker has left knee pain. She notes that she is unable to tolerate stairs, as she is in a great deal of pain. Her knee continues to buckle. The physical examination of the left knee reveals mild effusion, medial and lateral joint line tenderness to palpation, limits in range of motion secondary to pain, crepitus with range of motion, and mildly antalgic gait. Knee surgery has been denied. The treating physician did not document the duration of use of the requested cold therapy unit. The criteria noted above not having been met. Cold Therapy E0218 is not medically necessary.

Continuous Passive Motion Machine E0935: 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 chapter - Continuous passive motion (CPM).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg, Continuous Passive Motion.

Decision rationale: The requested Continuous Passive Motion Machine E0935 is not medically necessary. California Medical Treatment Utilization Schedule (MTUS) does not address this request. Official Disability Guidelines (ODG), Knee & Leg chapter, Continuous Passive Motion, state: "Criteria for the use of continuous passive motion devices: In the acute hospital setting, postoperative use may be considered medically necessary, for 4-10 consecutive days (no more than 21), for the following surgical procedures: (1) Total knee arthroplasty (revision and primary) (2) Anterior cruciate ligament reconstruction (if inpatient care) (3) Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint (BlueCross BlueShield, 2005) For home use, up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight: (1) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision; this may include patients with: (a) complex regional pain syndrome; (b) extensive arthrofibrosis or tendon fibrosis; or (c) physical, mental, or behavioral inability to participate in active physical therapy. (2) Revision total knee arthroplasty (TKA) would be a better indication than primary TKA, but either OK if #1 applies." The injured worker has left knee pain. She notes that she is unable to tolerate stairs, as she is in a great deal of pain. Her knee continues to buckle. The physical examination of the left knee reveals mild effusion, medial and lateral joint line tenderness to palpation, limits in range of motion secondary to pain, crepitus with range of motion, and mildly antalgic gait. Knee surgery has been denied. The treating physician has not documented the medical necessity for use of this device beyond the referenced guideline recommended time period. The criteria noted above not having been met. Continuous Passive Motion Machine E0935 is not medically necessary.