

Case Number:	CM14-0119535		
Date Assigned:	08/06/2014	Date of Injury:	02/08/2007
Decision Date:	10/22/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/29/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 records presented for review indicate that this 54 year-old male was reportedly injured on 2/8/2007. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated 6/10/2014, indicates that there are ongoing complaints of chronic right knee pain. The physical examination demonstrated right knee: anterior crepitus, positive tenderness to palpation over the inferior patellar pole, fat pad, and lateral retinaculum. Medial/lateral patellar gliding was tight. Lateral retinaculum was tight. Positive patellar compression test in the prone position. Quad tendon was tight. Diagnostic imaging studies mentioned the previous MRI of the right knee which revealed chondral defect patella. Previous treatment includes medications, and conservative treatment. A request had been made for interferential stimulation unit 2 month rental with supplies, conductive garment knee sleeve, and was not certified in the pre-authorization process on 6/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inferential Stimulator Unit (2-month rental with supplies): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: MTUS guidelines do not support Interferential Therapy as an isolated intervention. Guidelines will support a one-month trial in conjunction with physical therapy, exercise program and a return to work plan if chronic pain is ineffectively controlled with pain medications or side effects to those medications. Review of the available medical records, fails to document any of the criteria required for an IF Unit one-month trial. As such, the request for Inferential stimulator unit, two-month rental with supplies is not medically necessary.

Conductive Garment Knee Sleeve: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113-116.

Decision rationale: Because the interferential unit requested above has been deemed not medically necessary, the request for the conductive garment knee sleeve is also not medically necessary.

Wheelchair (1-month rental): 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 and Leg, Acute and Chronic, Wheelchair.

Decision rationale: ODG recommends the use of a wheelchair if the patient requires, and will use a wheelchair to move around in the residence, and is prescribed by a physician. After review the medical records provided it is noted the injured worker has recently had right knee arthroscopy, and at the first postop visit treating physician states he presented with a large knee effusion which was subsequently aspirated. There is no documentation that the patient is unable to ambulate with or without assistive devices. Therefore this request for a one month rental for wheelchair is not medically necessary.

Cold Therapy with DVT Compression Device (1-month rental): 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 (Acute & Chronic)

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, Acute and Chronic, Cold Therapy Unit

Decision rationale: ODG guidelines state continuous flow cryotherapy is "recommended as an option after surgery, but not for nonsurgical treatment. It may be used up to seven days including home use." This device is typically used for patients who have had a total knee arthroplasty or significant ligament reconstruction. After review of the medical records provided it is noted the patient did have knee surgery, however it was an arthroscopic procedure. Therefore, this request is not medically necessary.