

Case Number:	CM14-0136248		
Date Assigned:	09/03/2014	Date of Injury:	03/23/2010
Decision Date:	11/21/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/25/2014

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 Orthopedic Surgery and is licensed to practice California. 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:

This 55-year-old female textile worker sustained an industrial injury on 3/23/10. The patient reported an onset of low back, right shoulder, and neck pain pulling wet tangled blankets. Records documented conservative treatment requests for chiropractic, physical therapy, topical compounds, anti-inflammatory medication, muscle relaxant, opioid pain medication, and proton pump inhibitor. Extracorporeal shockwave therapy was documented to the cervical spine for a diagnosis of myofascial pain syndrome. Eight visits of physical therapy for the lumbar spine were documented from 2/6/14 to 3/19/14. Acupuncture was provided for chief complaint of lumbar spine pain with the 21st visit documented on 2/25/14. The 6/5/13 right knee MRI impression documented grade II chondromalacia patella. There was a board malacic circumferential tear of the posterior horn and body of the medial meniscus that communicated with the meniscocapsular junction. There was loss of articular cartilage, marrow edema on the tibial greater than femoral side of the medial articulation. The 7/3/14 treating physician report cited complaints of grade 10 lower back, headache, bilateral leg, bilateral shoulder, neck, and right arm pain with swelling. Physical exam documented tenderness to palpation. The diagnosis was right knee pain. Authorization was requested for right knee surgery. The patient was off work. The 8/7/14 utilization review denied the requests for cold therapy unit and knee brace as the associated meniscectomy was non-certified. There is no evidence that right knee meniscectomy was subsequently approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 and Leg, Continuous flow cryotherapy

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option for up to 7 days after knee surgery. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, there is no evidence that the requested meniscectomy has been approved. Additionally, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

Knee Brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Knee braces

Decision rationale: The California MTUS guidelines state that a knee brace can be used for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability although benefits may be more emotional (i.e., increasing the patient's confidence) than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. The Official Disability Guidelines support the use of pre-fabricated braces for the following conditions: knee instability, ligament insufficiency/deficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental osteoarthritis, or tibial plateau fracture. Guideline criteria have not been met. There was a request for meniscectomy but there is no evidence that surgery was approved. Records do not support the medical necessity of meniscectomy relative to mechanical symptoms, clinical exam findings, or failed conservative treatment consistent with guidelines. The use of a knee brace for this patient in the absence of surgery fails to meet guideline criteria. Therefore, this request is not medically necessary.

Pain Pump: 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative pain pump

Decision rationale: The California MTUS guidelines are silent regarding this device. The Official Disability Guidelines state that post-operative pain pumps are not recommended. Guidelines state there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. Three recent moderate quality randomized controlled trials did not support the use of pain pumps. There is no compelling reason to support the medical necessity of a pain pump for this patient. Given the absence of guideline support for the use of post-operative pain pumps, this request for pain pump purchase is not medically necessary.