

Case Number:	CM14-0148574		
Date Assigned:	09/18/2014	Date of Injury:	11/06/2013
Decision Date:	10/16/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	09/12/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in 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 is a case of a 59-year-old male who has filed a claim for healing MCL sprain and chondromalacia patella, left knee associated with an industrial injury date of 11/06/2013. Medical records from to 2014 were reviewed. Latest progress reports show that the patient reports unchanged symptoms since last visit regarding his left knee. He notes less swelling, but continues to have 8/10 pain. He notes that he has modified activities. Physical examination shows mild decrease knee flexion at 120 degrees associated with pain upon ROM testing. There is tenderness over the proximal medial collateral ligament and over the medial joint line. McMurray's test causes pain and discomfort but does not localize symptoms. Lachman's, anterior drawer, lateral patellar apprehension, and patellar apprehension are all negative. Motor and sensation are intact. MRI of the left knee last 02/12/2014 showed mild chondromalacia within the patellofemoral compartment and minimal chondromalacia within the medial compartment. Treatment to date has included medications, physical therapy, cortisone injection, braces, and activity modification. Medications taken include ibuprofen, Naprosyn, and Norco. Utilization review dated 08/13/2014 denied the request for rental of multi-stim unit and stimulator unit supplies because there was no history of prior treatment and treatment failure documented. The request for a home rehab kit was likewise denied because the treating physician has not described a home exercise program for the knee and has not described the components of the kit and how it will provide functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Rental- Multi Stim Unit trail (months)Qty;1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation) Page(s): 114,116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit; Neuromuscular Electrical Stimulation Page(s): 114-116; 121.

Decision rationale: A search of online resources showed that the Pro-tech Multi-Stim unit is a combination of TENS, interferential unit, and neuromuscular stimulator. CA MTUS does not recommend TENS as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option for neuropathic pain and CRPS, if used as an adjunct to a program of evidence-based functional restoration, with the following criteria: (1) documentation of pain of at least three months duration with evidence that other appropriate pain modalities have been tried (including medication) and failed, (2) a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial, (3) other ongoing pain treatment should also be documented during the trial period including medication usage (4) a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted, and (5) 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. CA MTUS also states that there are no intervention trials suggesting benefit from NMES for chronic pain; hence, it is not recommended unless following stroke. In this case, the patient was prescribed additional physical therapy but it is unclear if he is actively participating in it currently. The use of TENS and interferential unit is only recommended as adjunct to a functional restoration program. Furthermore, there was no documentation of treatment failure from appropriate treatment modalities in the submitted documents. Moreover, there was no documentation of a previous stroke to support the need for NMES use. The request likewise failed to specify the body part to be treated. Therefore, the request for Rental- Multi Stim Unit trail (months) Qty; 1.00 is not medically necessary.

Stimulator Unit supplies months Qty:3.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation) Page(s): 114,116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit; Neuromuscular Electrical Stimulation Page(s): 114-116; 121.

Decision rationale: The related request for Rental- Multi Stim Unit trail has been deemed not medically necessary; therefore, all of the associated services, such as this request for Stimulator Unit supplies months Qty: 3.00 is likewise not medically necessary.

Optimum Home Rehab Kit Qty 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines - Home Exercise Kits.

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 Chapter, Home Exercise Kits

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines was used instead. ODG Knee Chapter recommends home exercise kits as an option where home exercise programs and active self-directed home physical therapy are recommended. In this case, the patient had undergone physical therapy and has been reviewed the home exercises in the sessions. However, there was no discussion regarding the medical need for a home exercise kit. Moreover, the exact content of the exercise kit was not described in the records. It is unclear if the included equipment will be considered for medical treatment. The clinical indication for this request has not been established. Therefore, the request for Optimum Home Rehab Kit Qty 1.00 is not medically necessary.