

Case Number:	CM14-0168836		
Date Assigned:	10/16/2014	Date of Injury:	04/04/2013
Decision Date:	11/18/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	10/13/2014

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, has a subspecialty in Interventional Spine 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:

The patient is a 45-year-old male with date of injury of 04/04/2013. The listed diagnoses per [REDACTED] from 05/08/2014 are: 1. Musculoligamentous sprain, cervical spine. 2. Disk degeneration, C5-C6. 3. Mild acromioclavicular joint degenerative changes. 4. Large full-thickness tear of the supraspinatus tendon. 5. Retraction of the musculotendinous junction and muscle atrophy. According to this report, the patient complains of lumbar spine pain, right knee, and left knee pain. The patient reports popping, tingling, and numbness in the right knee. There is discomfort when standing, walking, and bending at the knees. The examination shows the patient walks with an antalgic gait favoring the left leg. The patient uses a cane on the right. She has difficulty with toe and heel walking bilaterally. There is hypoesthesia noted on the right over the L5 and S1 dermatomes. Sensation is within normal limits on the right at L3 and L5 or dermatomes as well as on the left at L3, L5, L5 and S1 dermatome. Crepitation is positive bilaterally. McMurray's sign is positive on the right. Range of motion of the bilateral knees is diminished. The MRI of the right knee from 12/14/2013 shows osteochondroma of the distal femoral diaphysis laterally. Moderate, deformity of the medial femoral condyle, most likely related to prior trauma. Mild to moderate subchondral degenerative changes of the medial tibial femoral condyle and medial tibial plateau articular cartilage. The utilization review denied the request on 09/22/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 day rental of a surgistim multi modality stimulator unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 114-11.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation; www.zapconnect.com Page(s): 111 to 120.

Decision rationale: This patient presents with left shoulder pain. The treating physician is requesting a 30-day rental of a Surgi Stim multimodality stimulator unit. According to Zapconnect.com site, Surgi Stim stimulator unit is registered with FDA as NeuroMuscular Electrical Stimulator (NMES). MTUS guidelines do not support NMES for chronic pain condition, only supporting it for stroke rehab. While TENS and other electrical stimulation units are supported, NMES is not. The request is not medically necessary.

14 day rental of a cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition (web), 2014, Knee and 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 (ODG) Knee chapter Continuous-flow cryotherapy

Decision rationale: This patient presents with left shoulder pain. The treating physician is requesting a 14-day rental of a cold therapy unit. The MTUS and ACOEM Guidelines are silent with regards to this request. However, ODG Guidelines on continuous-flow cryotherapy states that it is recommended as an option after surgery, but not for non-surgical treatment. Postoperative use generally maybe up to 7 days including home use. The records show that the treating physician requested a right knee arthroscopy with chondroplasty and meniscectomy. However, it is unclear from the records if the patient was authorized for this procedure. The treating physician does not discuss a scheduled surgery and the utilization review does not show a denial or an authorization of the said surgery. In this case, ODG Guidelines supports the use of continuous-flow cryotherapy following surgery but just for 7 days. The current request is for 30 days. Therefore, this request is not medically necessary.

30 day rental of a continuous passive motion machine unit.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 11th Edition (web), 2014, Knee and Leg Chapter, Continuous Passive Motion.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) under Knee/Leg Chapter on Continuous Passive Motion (CPM)

Decision rationale: This patient presents with left shoulder pain. The treating physician is requesting a 30-day rental of a continuous passive motion machine unit. The MTUS and ACOEM Guidelines do not address this request; however, ODG Guidelines on CPM for knee condition states that it is recommended for in-hospital use, but not routinely for home use. The criteria for use includes: total knee arthroplasty; acute cruciate ligament reconstruction and open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint. Postoperative use may be considered medically necessary in the acute hospital setting for 4 to 10 consecutive days, no more than 21 days. The 07/24/2014 report notes crepitation is positive bilaterally. McMurray's sign is positive on the right. Range of motion of the bilateral knees is diminished. The MRI of the right knee from 12/14/2013 shows osteochondroma of the distal femoral diaphysis laterally. Mild to moderate subchondral degenerative changes of the medial tibial femoral condyle and medial tibial plateau articular cartilage. It does not appear that the patient's knee surgery has been authorized and scheduled. In this case, ODG Guidelines does not support the use of this device outside the hospital setting and the requested 30-day rental exceeds ODG's 21-day treatment recommendation. This request is not medically necessary.