

Case Number:	CM14-0072454		
Date Assigned:	08/29/2014	Date of Injury:	06/29/2012
Decision Date:	10/17/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/19/2014

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 Medicine and is licensed to practice in Texas. 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 injured worker is a 40 year old male whose date of injury is 06/29/2012. The injured worker was pulling an airline from the service truck, walking backward and hit something with the back of his heel. Treatment to date includes left knee meniscectomy on 11/18/12, left knee arthroscopy on 06/20/13, right knee arthroscopy on 01/30/14 and left sided L5 and S1 transforaminal epidural steroid injection on 12/11/13. Evaluation dated 03/19/14 indicates that diagnoses are chronic sprain/strain of thoracolumbar spine, status post left knee arthroscopy with recurrent meniscal tear, right knee overuse syndrome, overuse syndrome of back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Combo-stim electrotherapy motorized cold therapy unit for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Cold/heat packs

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs

Decision rationale: Based on the clinical information provided, the request for combo-stim electrotherapy motorized cold therapy unit for purchase is not recommended as medically necessary. There is no support for the requested unit in CA MTUS, ACOEM or the Official Disability Guidelines. There is no clear rationale provided to support the requested unit. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals are provided. Therefore, Combo-stim electrotherapy motorized cold therapy unit for purchase is not medically necessary and appropriate.