

<b>Case Number:</b>	CM15-0033574		
<b>Date Assigned:</b>	02/27/2015	<b>Date of Injury:</b>	11/07/2011
<b>Decision Date:</b>	04/13/2015	<b>UR Denial Date:</b>	02/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 (IW) is a 47-year-old male who sustained an industrial injury on 11/07/2011. He has reported left knee pain and clicking. Diagnoses include patellofemoral malalignment of the right knee. Treatment to date includes medications, injections, bracing and rest. A progress note from the treating provider dated 01/21/2015 state that clinical examination of the right knee and MRI studies present evidence of patellofemoral malalignment of the right knee. X-Rays show lateral tracking of the patella. The MRI report of 01/150/2015 reports 1. Intact collateral and cruciate ligaments; 2.No meniscal tear; and 3. Grade 2/3 chondromalacia of the patella. The treatment plan is for a diagnostic and operative arthroscopy of the right knee with patella stabilization. On 02/11/2015, Utilization Review modified a request for Cold therapy unit to a 7 day rental of a cold therapy unit. The ODG were cited. On 02/11/2015 Utilization Review non-certified a request for DME: purchase of shoulder sling. No reference was given. On 02/11/2015 Utilization Review non-certified a request for One (1) month rental of an Interferential (IF) unit. The MTUS Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME: purchase of shoulder sling: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

**Decision rationale:** Based on the 12/03/14 progress report, the patient complains of persistent neck pain, which remains primarily localized to the neck with radiation to the arms, bilateral knees and wrist pain. The request is for DME: PURCHASE OF SHOULDER SLING. The requesting progress report is not included in provided documentation and there is no RFA. The patient is status post operative arthroscopy of the left wrist, per operative report 10/14/14. Physical examination to the cervical spine revealed marked tenderness of the paratrapezial musculature bilaterally with spasm of the right trapezius. Range of motion is decreased with 40 degree extension. The patient is temporarily totally disabled. MTUS/ACOEM, chapter 9, page 204, table 9-3, Recommendations under Options for Rotator Cuff tear: "Sling for acute pain" or for AC joint strain "Sling for comfort." Shoulder sling is indicated for acute pain or for AC joint strain. However, this patient does not present with shoulder pain. The reviewed reports do not describe any shoulder symptoms. There is no explanation or rationale for the prescribed shoulder sling. Therefore, the request IS NOT medically necessary.

**Cold therapy 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 Pain Chapter under continuous flow cryotherapy.

**Decision rationale:** Based on the 12/03/14 progress report, the patient presents with persistent neck pain, which remains primarily localized to the neck with radiation to the arms, bilateral knees and wrist pain. The request is for COLD THERAPY UNIT. The requesting progress report is not included in provided documentation and there is no RFA. The patient is status post operative arthroscopy of the left wrist, per operative report 10/14/14. Physical examination to the cervical spine revealed marked tenderness of the paratrapezial musculature bilaterally with spasm of the right trapezius. Range of motion is decreased with 40 degree extension. The patient is temporarily totally disabled. The MTUS and ACOEM Guidelines do not discuss water therapy units. ODG Guidelines Pain Chapter under continuous flow cryotherapy states, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In a postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." The treater does not provide a rationale for the request and has not indicated how the unit will be used. ODG Guidelines do not support this type of device other than for postoperative recovery. The treater does not request the unit for 7 days post-op. The treater does not say that this is to be used for

post-op. Cold therapy units are not recommended for chronic pain. The request IS NOT medically necessary.

**One (1) month rental of an Interferential (IF) unit:** 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 Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** Based on the 12/03/14 progress report, the patient presents with persistent neck pain, which remains primarily localized to the neck with radiation to the arms, bilateral knees and wrist pain. The request is for ONE MONTH RENTAL OF AN INTERFERENTIAL (IF) UNIT. The requesting progress report is not included in provided documentation and there is no RFA. The patient is status post operative arthroscopy of the left wrist, per operative report 10/14/14. Physical examination to the cervical spine revealed marked tenderness of the paratracheal musculature bilaterally with spasm of the right trapezius. Range of motion is decreased with 40 degree extension. The patient is temporarily totally disabled. For Interferential Current Stimulation (ICS), MTUS guidelines, pages 118 - 120, state that "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). In this case, none of the progress reports discuss this request. The treater does not explain the need for an interferential unit. There is no mention that medications are ineffective, poorly tolerated or that the patient has history of substance abuse. The patient is post-operative, but the treater does not explain that the patient's post-op pain is poorly controlled or that post-op therapy intervention has not been helpful. The request IS NOT medically necessary.