

<b>Case Number:</b>	CM15-0096288		
<b>Date Assigned:</b>	05/28/2015	<b>Date of Injury:</b>	11/15/2013
<b>Decision Date:</b>	06/25/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2015

### 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 is a 45 year old male, who sustained an industrial injury on 11/15/2013. He reported neck, bilateral shoulder, low back and left inguinal region pain after lifting and stacking batteries. The injured worker was diagnosed as having lumbar sprain/strain with pre-existing degenerative changes. Treatment to date has included physical therapy, magnetic resonance imaging of right shoulder (11/17/2014), magnetic resonance imaging of left shoulder (11/17/2014), magnetic resonance imaging of the cervical spine (11/17/2014), magnetic resonance imaging of the lumbar spine (11/17/2014), and epidural injections. The request is for knee brace, hot/cold therapy unit with pad and wraps, IF unit one month renal and supplies with electrodes and batteries. On 1/29/2015, he complained of sharp neck pain with radiation into the bilateral shoulders and back of the head; bilateral shoulder pain with radiation down the arms to the wrists/hands; low back pain with radiation into the hips and down the legs to the feet; left inguinal pain present when walking, and difficulty with restful sleep. Physical findings are revealed to be: cervical spine with good lordosis, no pain to palpation, mild discomfort noted with flexion and extension; upper extremities: no pain with palpation, normal range of motion, and negative Tinel signs at the wrists bilaterally; lumbar spine: no spasms, mild pain to the lower lumbar spine, moderate pain with flexion and extension; lower extremities: negative straight leg raise testing. Treatment recommendations were to be made after full review of all diagnostic studies and imaging.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Knee Brace (Purchase): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Knee Brace.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Chapter Knee: Bracing, page 339-340.

**Decision rationale:** Guidelines states knee bracing is a treatment option in conjunction with an active exercise program for diagnoses of significant osteoarthritis to delay possible total knee arthroplasty. Clinical exam has not demonstrated any severe acute red-flag conditions or limitation in ADLs as a result of the patient's knee condition to support for this active knee brace. Additionally, per Guidelines, prefabricated knee braces may be appropriate in patients with one of the following conditions such as 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 uni-compartmental osteoarthritis; or Tibial plateau fracture. Functional knee braces may be considered medically necessary in the treatment of a chronically unstable knee secondary to a ligament deficiency. The medial and lateral hinge and derotational types specifically used to treat collateral ligament and cruciate ligament and/or posterior capsule deficiencies should be the "off the shelf" type. The medical necessity of an active brace may be an individual consideration in patients with abnormal limb contour, knee deformity, or large size, all of which would preclude the use of the "off the shelf" model. Submitted reports have not adequately demonstrated the indication or clinical findings to support this knee brace. The Knee Brace (Purchase) is not medically necessary and appropriate.

**Hot/Cold Therapy Unit with Pads and Wraps (Purchase): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Cryotherapy/Cold & Heat Packs, pages 381-382.

**Decision rationale:** The unit provides heat and cold compression therapy wrap for the patient's home for indication of pain, edema, for post-operative orthopedic patients. Submitted reports have not demonstrated factors meeting criteria especially rehabilitation to include mobility and exercise are recommended postsurgical procedures as a functional restoration approach towards active recovery; however, none is demonstrated here. MTUS Guidelines is silent on specific use of cold compression therapy with pad and wrap, but does recommend standard cold pack for post exercise. ODG Guidelines specifically addresses the short-term benefit of cryotherapy post-surgery; however, limits the use for 7-day post-operative period, as efficacy has not been proven

after. Submitted reports have not adequately demonstrated indication, clinical findings, or comorbidities to support the unit beyond guidelines criteria. The Hot/Cold Therapy Unit with Pads and Wraps (Purchase) is not medically necessary and appropriate.

**IF Unit, One Month Rental and Supplies: Electrodes x 10 pack, Batteries x 10:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Therapy Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, pages 115-118.

**Decision rationale:** The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved functional status derived from any transcutaneous electrotherapy to warrant an interferential unit for home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process with return to work and exercises not demonstrated here. The IF Unit, One Month Rental and Supplies: Electrodes x 10 pack, Batteries x 10 is not medically necessary and appropriate.