

Case Number:	CM13-0048386		
Date Assigned:	12/27/2013	Date of Injury:	12/27/2012
Decision Date:	03/04/2015	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	11/05/2013

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, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 33 year old female sustained work related industrial injuries on December 27, 2012. The mechanism of injury involved pulling a pallet of car batteries when the injured worker experienced a pop in her left knee. The injured worker subsequently complained of low back pain with radiation to left lower extremity and left knee pain. Treatment consisted of MRI of left knee, electromyography, prescribed medications, chiropractic treatments, physical therapy, consultation, and periodic follow up visits, MRI of the left knee dated January 16, 2013, was unremarkable. Electromyography on September 25, 2013 revealed dermatomal somatosensory evoked potentials of the L5 and S1 nerves were within normal limits. Per most recent treating provider report dated August 28, 2013, physical exam revealed antalgic gait, favoring the left lower extremity. There was decrease range of motion on the lumbosacral spine and positive straight leg raising on the left noted on exam. There was tenderness and spasm noted to palpitation of the paralumbar and gluteal musculature bilaterally and tenderness over the sacroiliac joints, sciatic notch and posterior iliac crest bilaterally. Left knee exam revealed swelling, medial joint line and medial tibia condyle tenderness, normal range of motion, and positive McMurray test. Full range of motion was noted in the hips and knees with no apparent deformity or instability. The patellar and Achilles reflexes were bilaterally decreased. Sensation was decreased over the left thigh, knee, leg, and foot with decreased motor strength of the left knee. The injured worker's diagnoses included lumbosacral musculoligamentous strain/sprain with radiculitis, rule out disc protrusion, left knee strain/sprain, rule out meniscal tear and sleep disturbance secondary to pain. As of August 28, 2013, the injured worker remains on modified

duty. The treating physician prescribed services for IF (Interferential Unit) and cold therapy unit now under review. On October 10, 2013, the Utilization Review (UR) evaluated the prescription for IF unit and cold therapy unit requested on October 3, 2013. Upon review of the clinical information, UR non-certified the request for IF unit, noting lack of sufficient clinical documentation supporting failed first line treatments and the recommendations of the MTUS and the Official Disability Guidelines. UR non-certified the request for cold therapy unit, noting cold therapy unit is used immediately post op recovery period and not otherwise on a routine basis, and the recommendations of the MTUS and the Official Disability Guidelines. The UR decisions were subsequently appealed to the Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF (Interferential Unit): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Unit Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential unit Page(s): 1180120. Decision based on Non-MTUS Citation Pain section, interferential unit

Decision rationale: Pursuant to the Official Disability Guidelines, an interferential unit (ICS) is not medically necessary. ICS is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with the recommended treatments, including return to work, exercise and medications. Patient selection criteria are enumerated in the official disability guidelines and need to be documented for the ICS to be medically necessary. They include, but are not limited to, pain ineffectively controlled due to diminished effectiveness of medicines or due to side effects of medications; unresponsive to conservative measures; history of substance abuse; and significant pain from post operative or acute conditions; etc. If those criteria are met, then a one month trial may be appropriate to permit the physician and physical therapy provided to study the effects and benefits. This should be increase functional improvement, less reported pain in evidence of medication reduction associated with the one-month trial. In this case, the injured workers working diagnoses are lumbosacral musculoligamentous strain/sprain with radiculitis, rule out disc protrusion; left knee strain/sprain, rule out meniscal tear; and sleep disturbance secondary to pain. The documentation did not contain evidence of a one month ICS trial. The injured worker receives physical therapy, diagnostic studies, medications. The documentation did not state what body regional body part was to be treated with ICS. The subjective complaints were limited to the low back and left knee. Documentation in the medical records not contain documentation as to whether pain was ineffectively control due to diminished effectiveness of medicines or side effects of medications. There was no documentation of objective functional improvement or non-improvement physical therapy. Again, there was no documentation of one month trial with ICS. Consequently, absent clinical documentation to support the patient selection criteria enumerated in the official disability guidelines and a one month trial with an ICS unit, an interferential unit is not medically necessary.

Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 1015-1017, 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Low Back, Continuous-flow cryotherapy, cold/heat packs

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain section, Cold therapy unit

Decision rationale: Pursuant to the Official Disability Guidelines, cold therapy unit is not medically necessary. Cold/heat packs are recommended as an option for acute pain. At home local applications of cold packs are recommended in the first few days of acute complaint, thereafter applications of heat packs or cold packs. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. In this case, the injured workers working diagnoses are lumbosacral musculoligamentous strain/sprain with radiculitis, rule out disc protrusion; left knee strain/sprain, rule out meniscal tear; and sleep disturbance secondary to pain. The documentation does not contain a clinical indication or rationale for the cold therapy unit. The injured worker's subjective complaints were limited to the left knee in the low back. Continuous flow cryotherapy is not clinically indicated. Consequently, absent clinical documentation to support the use of a cold therapy unit, cold therapy is not medically necessary.

Left knee sleeve: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Compression garments

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee section, Knee braces

Decision rationale: Pursuant to the Official Disability Guidelines, left knee sleeve is not medically necessary. There are no high-quality studies that support or refute the benefits of knee braces for patellar instability, ACL tear MCL instability, but in some patients and knee brace can increase confidence, which may indirectly help feeling process. In all cases, braces need to be used in conjunction with a rehabilitation program and are necessary only if the patient is going to be stressing the need under load. There are two types of knee braces: a prefabricated knee brace and a custom fabricated knee brace. A knee sleeve provides warmth, compression and basic support for minor injuries and pain. In this case, the injured worker's working diagnoses are lumbosacral musculoligamentous strain/sprain with radiculitis, rule out disc protrusion; left knee strain/sprain, rule out meniscal tear; and sleep disturbance secondary to pain. The injured worker has subjective complaints of low back pain and knee pain that increase connectivity. Examination of the knee reveals tenderness the positive McMurray's test. There is no deformity

or instability. The treating physicians plan is a left knee sleeve. The injured worker had an MRI of left knee January 16 May 13 that was unremarkable. There is no clinical indication or clinical rationale for the left knee sleeve. Consequently, absent clinical documentation to support the use of the left knee sleeve, the left knee sleeve is not medically necessary.