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## Independent Medical Review Final Determination Letter

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/31/2013

<b>IMR Case Number:</b>	CM13-0018762	<b>Date of Injury:</b>	09/22/2010
<b>Claims Number:</b>	[REDACTED]	<b>UR Denial Date:</b>	08/20/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/30/2013
<b>Employee Name:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED] MD		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
DME: KNEEHAB UNIT FOR PURCHASE, WITH CONDUCTIVE GARMENT			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Reconstructive Surgery and is licensed to practice in Illinois, Texas and Wyoming. 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 physician 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.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 61-year-old female who reported an injury on 11/29/2010 due to a fall. The patient underwent an MRI that revealed lateral tracking of both patellas in the neutral position with centralization of the patella on the 15 and 30 degrees of flexion images. The patient's surgical history included knee surgery in 1994 and 2011. The patient again underwent surgical intervention which included arthroscopy of the left knee, chondroplasty, synovectomy, ligament reconstruction. The patient had postoperative physical therapy and was compliant with a home exercise program. The patient had persistent left knee pain and swelling. Physical findings included mild soft tissue swelling, mild medial patella tenderness, effusion, range of motion described as 130 degrees in flexion, and quadriceps strength rated at 4/5. The patient's diagnoses included chondromalacia of the patellar. The patient's treatment plan included a left knee brace, home exercise program, and outpatient physical therapy.

### IMR DECISION(S) AND RATIONALE(S)

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

**1. The Kneehab neuromuscular electrical stimulation device is not medically necessary and appropriate.**

The Claims Administrator based its decision on the the Chronic Pain Guidelines, page 121, which is a part of the MTUS, and the Official Disability Guidelines, which are not a part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, TENS, Criteria for use, page 116, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

The requested KneeHab neuromuscular electrical stimulation device is not medically necessary. The employee does have chronic pain complaints preventing activity and range of motion. California Medical Treatment Utilization Schedule does recommend a 1 month trial period of a TENS unit to be used as an adjunct to therapy when all other appropriate pain modalities have been attempted and failed to resolve the employee's symptoms. The clinical documentation submitted for review does indicate that the employee is being prescribed outpatient physical therapy. The efficacy of that therapy should be established prior to initiation of a trial of a TENS unit. Additionally, the request does not specifically identify whether this is a trial or for purchase. The purchase of a TENS unit is not supported unless there is a 1 month trial. There is no documentation of a trial and KneeHab neuromuscular electrical stimulator would not be indicated. **The request for the KneeHab device is not medically necessary and appropriate.**

/dso

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

CM13-0018762