

Case Number:	CM14-0101839		
Date Assigned:	07/30/2014	Date of Injury:	04/14/2012
Decision Date:	09/30/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/30/2014

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 Internal Medicine, has a subspecialty in Pulmonary Diseases and is licensed to practice in California. 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 53-year-old male with a reported date of injury on 04/14/2012. The mechanism of injury was due to a slip and fall. His diagnoses were noted to include oblique tear of medial meniscus to the right knee, lumbar disc degeneration with superimposed lumbosacral sprain, cervical sprain superimposed on pre-existing mild disc degeneration C5-6 and C6-7, status post left knee anterior cruciate ligament reconstruction and partial meniscectomy. His previous treatments were noted to include physical therapy, chiropractic treatment, corticosteroid injection, aquatic therapy, and acupuncture. The progress note dated 03/06/2014 revealed complaints of cervical back pain. The physical examination revealed tenderness to touch to the bilateral paravertebral muscles with the upper trapezius and decreased range of motion. There was a positive Spurling's and increased pain with range of motion. The examination of the right knee noted medial and lateral joint line pain with positive crepitus and McMurray's. There was decreased range of motion noted. The progress note dated 05/02/2014 revealed complaints of pain rated 4/10 to 10/10. The physical examination of the knee revealed full range of motion with positive right medial joint line tenderness and effusion. The special orthopedic tests were negative. Muscle strength was rated 5/5. There was a normal sensory examination and deep tendon reflexes were symmetric and equal. The provider indicated the injured worker was a candidate for right knee arthroscopy evaluation, arthroscopic partial medial meniscectomy, chondroplasty and debridement. The injured worker was advised that authorization for surgery would be obtained and that surgery could be scheduled at the earliest convenience. Request for Authorization form dated 05/02/2014 was for a postoperative home continuous passive motion device for an initial period of 14 days and a surgical stim unit for an initial period of 90 days and a Coolcare cold therapy unit for postoperative care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op surgi stim unit/cold care unit x90 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines , Galvanic Stimulation, page 117, interferential Current Stimulation, page 118, Neuromuscular electrical stimulation, page 121 Page(s): 117, 118, 121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)), Knee and Leg, Continuous-flow cryotherapy.

Decision rationale: The request for a postop surgical stimulator unit/cold care unit x 90 days is not medically necessary. The injured worker is awaiting authorization for knee surgery. The surgical stimulation device consists of interferential multi stimulation, neuromuscular electrical stimulation, and high voltage pulsed current stimulation. The California Chronic Pain Medical Treatment Guidelines do not recommend galvanic stimulation. Galvanic stimulation is characterized by high voltage, pulsed stimulation and is used primarily for local edema reaction through muscle pumping and polarity effect. The theory of galvanic stimulation is that by placing a negative electrode over the edematous site and a positive electrode at a distant site, the monophasic high voltage stimulus applies an electrical potential which disperses the negatively charged protons away from the edematous site, thereby helping to reduce edema. The guidelines do not recommend interferential current stimulation 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. The guidelines do not recommend neuromuscular electrical stimulation. Neuromuscular electrical stimulation is used primarily as a part of a rehabilitation program following a stroke and there is no evidence to support its use in chronic pain. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries, such as muscle strains and contusions, has not been fully evaluated. Continuous flow cryotherapy units provide regulated temperatures through the use of power to circulate ice water into the cooling packs. The guidelines do not recommend 2 of 3 components of the surgical stimulation unit within regards to the galvanic pulse and the neuromuscular electrical stimulation. The guidelines recommend for a cold care unit 7 day rental, and the request for a 90 day rental for both the surgical stimulation unit and cold care unit exceed guideline recommendations. Additionally, there is a lack of documentation regarding the approval for the knee surgery to warrant the postoperative items. Therefore, the request is not medically necessary.

Continuous passive motion devices x14 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Continuous Passive Motion.

Decision rationale: The request for a continuous passive motion device x 14 days is not medically necessary. The injured worker is awaiting approval for a medial meniscus tear arthroscopy surgical procedure. The Official Disability Guidelines recommend continuous passive motion for in hospital use or for home use in injured workers at risk of a stiff knee based on demonstrated compliance and measured improvements but the beneficial effects over regular physical therapy may be small. Routine home use of CPM has minimal benefits. Although research suggests that CPMs should be implemented in the first rehabilitation phase after surgery, there is substantial debate about the duration of each session and the total period of CPM application. The guideline's criteria for the use of a continuous passive motion device in the acute hospital setting is postoperative use may be considered medically necessary for 4 to 10 consecutive days (no more than 21) for total knee arthroplasty, anterior cruciate ligament reconstruction, and open reduction and internal fixation of the tibial plateau or distal femur fractures involving the knee joint. The guideline's criteria for home use is up to 17 days after surgery while injured workers are at risk of a stiff knee or are immobile or unable to bear weight. The guidelines recommend CPM under the conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision and this may include injured workers with complex regional pain syndrome; extensive arthrofibrosis or tendon fibrosis; or physical, mental, or behavioral inability to participate in active physical therapy. The guidelines also recommend CPM for revision of total knee arthroplasty which would be a better indication than primary total knee arthroplasty but either is ok if the injured worker is under the conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision. The injured worker has not received authorization for the medial meniscus tear repair indicated by the medical records submitted; however, the guidelines recommend a continuous passive motion device for anterior cruciate ligament reconstruction, total knee arthroplasty, or open reduction and internal fixation of tibial plateau and distal femur fractures involving the knee joint to which the injured worker has not been diagnosed. Therefore, the request is not medically necessary.