

Case Number:	CM13-0030139		
Date Assigned:	03/28/2014	Date of Injury:	06/08/2006
Decision Date:	04/28/2014	UR Denial Date:	09/16/2013
Priority:	Standard	Application Received:	09/26/2013

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. The expert reviewer is Board Certified in Physical Medicine 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 expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records: The ground collapsed beneath him causing him to hyperextend his knees sideways. He states that shortly after that, he tried to move but fell to the ground due to the immediate pain in his bilateral knees and low back. Prior treatment history has included physical therapy, medications, and manipulation. The patient underwent right knee arthroscopy in 09/2006; left knee arthroscopy in 10/2007; total knee replacement left knee with two revision surgeries, repair of a ruptured quadriceps in 08/2009; another revision surgery to the knee on 08/15/2011; arthrotomy and synovectomy of the left knee and debridement of the left knee with the removal and exchange of tibial liner on 09/16/2011; and knee aspiration status post left total knee arthroplasty on 08/22/2013. PR2 dated 08/09/2013 indicated the patient persists with left knee pain, swelling, and pain bearing weight. He has no fever, chills, or systemic complaints. Objective findings on exam revealed the left knee has 2+ effusions. There is painful motion from 5 to 55. There is instability throughout the arc of motion and the compartments are soft. Distally, he is neurovascularly intact. PR2 dated 08/07/2013 documented the patient to have complaints of continued pain involving his left knee and uses crutches for ambulation. He has also undergone treatment at USC with infectious disease specialist. Objective findings on exam revealed his left knee shows well-healed anterior incision. His range of motion shows that he has an 80 degree flexion contracture. He is unable to extend or bend his left leg. He has obvious swelling. There is no erythema, drainage or obvious evidence of infection. His right knee reveals tenderness to the medial and lateral joint line, positive McMurray's and pain with squatting maneuver. The patient was diagnosed with 1) A history of industrial injury to bilateral knees on June 8, 2006; 2) Status post left knee total arthroplasty on June 2011 with resurfacing procedure on August 2011, quadriceps repair on October 2011 and revision total knee arthroplasty with

long stem component on March 2012 with washout procedure on October 2012; and 3) Multiple infections to the left knee

IMR ISSUES, DECISIONS AND RATIONALES

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

PRILOSEC 20MG BID #60 QTY60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, NSAIDs, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s).

Decision rationale: The CA MTUS guidelines state medications such as Prilosec may be indicated for patients at risk for gastrointestinal events, which should be determined by the clinician: 1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The medical records do not document the patient's current medication regimen. The medical records do not establish that any of these criteria apply to this patient. The medical records do not establish any of the above listed criteria exist in this case that would indicate he is at risk for gastrointestinal events, to warrant access to the proton pump inhibitor. Based on the lack of documentation, the request is non-certified.

HOME HEALTH CARE AT 4 HOURS PER DAY, 3 DAYS A WEEK FOR 6 WEEKS, QTY:1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) OFFICIAL DISABILITY GUIDELINES-TREATMENT FOR WORKERS' COMPENSATION (TWC): WWW.ODGTREATMENT.COM, WORK LOSS DATA INSTITUTE (WWW.WORKLOSSDATA.COM), (UPDATED 2/14/12)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, HOME HEALTH SERVICES Page(s): 51.

Decision rationale: The patient underwent left knee replacement in August 2013. There is no indication in the records that the patient is homebound, and requires medical treatment or care in the home. It is not established that the patient is not be able to manage medications, or tend to any other personal requirements. The guidelines do not support home health care services for activities relating to personal care such as grooming, dressing, and bathing, or homemaker services such as assistance with food preparation, shopping, or housekeeping. The request is not supported by the guidelines, the medical necessity of this request has not been established.

ASSISTANCE WITH TRANSPORTATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) OFFICIAL DISABILITY GUIDELINES TREATMENT FOR WORKERS' COMPENSATION (TWC) WEB, KNEE & BACK (ACUTE & CHRONIC) (UPDATED 07/19/12).

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, TRANSPORTATION (TO & FROM APPOINTMENTS)

Decision rationale: The medical records document the patient underwent left knee arthroplasty in August 2013. The documentation submitted does not establish the patient requires assistance with transportation. It is reasonable that the patient would be able to transport himself to and from appointments, and potentially enlist the assistance of family and friends with transportation. The medical necessity of this request has not been established.

HANDRAILS TO BE INSTALLED IN THE SHOWER AND TUB QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) OFFICIAL DISABILITY GUIDELINES TREATMENT

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) KNEE & LEG, DURABLE MEDICAL EQUIPMENT (DME)

Decision rationale: According to the guidelines, most bathroom supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. Medical conditions that result in physical limitations for patients may require patient education, but environmental modifications are considered not primarily medical in nature. The patient underwent left knee arthroplasty in August 2013. It is reasonable that the patient will be able to safely maneuver within his bathroom and shower and bathe, and would not require placement of handrails to do so. Therefore the request is non-certified.

MOTORIZED WHEELCHAIR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, POWER MOBILITY DEVICES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, POWER MOBILITY DEVICES (PMDs), Page(s): 99.

Decision rationale: The guideline state power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or

the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized wheelchair is not essential to care. The 8/7/2013 medical report documents the patient ambulated with crutches. The medical records do not establish a motorized wheelchair is essential and medically necessary for this patient.