

Case Number:	CM13-0068621		
Date Assigned:	01/03/2014	Date of Injury:	10/13/2003
Decision Date:	06/19/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/19/2013

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 Orthopedic Surgery, 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 patient is an employee of [REDACTED] and has submitted a claim for left knee osteoarthritis with tear of medial cartilage or meniscus, right shoulder rotator cuff tear, low back syndrome, lumbar disk syndrome, and cervical disk syndrome associated with an industrial injury date of October 13, 2003. Treatment to date has included left knee arthroscopy, medial and lateral meniscectomy on July 9, 2010; physical therapy, 5 cortisone injections into the left knee, four lumbar epidural steroid injections, and medications such as Vicodin, Relafen, Flexeril, and Prilosec. Medical records from 2012 to 2013 were reviewed, showing the patient complained of neck pain graded 7/10, low back pain rated 7/10, and left knee pain graded 8/10 in severity. The patient noted knee locking with loss of spinal rhythm and giving way. Physical examination revealed tenderness and spasm over the cervical spine and lumbar spine with loss of spinal rhythm. Grip strength of right by Jamar dynamometer showed 22/20/23 compared to 27/20/29 of the left hand. Motor strength of the right lower extremity was graded 4/5 compared to 4-/5 at the left. X-ray examination of the right knee, on unspecified date, revealed the joint compartments to be well maintained. X-ray examination of the left knee, on unspecified date, revealed 2-3 millimeter medial joint space and 2 millimeters patellofemoral joint space. MRI of the left knee, dated 11/15/2008, revealed mild chondromalacia patella with severe degenerative loss of articular cartilage thickness in the medial compartment of the knee. The medial meniscus was diffusely abnormal consistent with tears extending to the superior and inferior articular surface involving the posterior horn and body with extension into the adjacent portion of the anterior horn which reached the superior articular surface. A small joint effusion was present. Utilization review from November 26, 2013 denied the requests for DME purchase - knee brace due to lack of indication; DME purchase - walker since surgery has been non-certified; Injection-Lovenox injections x 14 days since surgery has been non-certified; home health care (bathing,

medication, wound care, walking) 3 hours a day/5 days a week/4 weeks due to lack of documentation whether it was for her pre-or post operative use; preoperative medical clearance because the surgery has been non-certified; postoperative physical therapy, two times per week for 6 weeks because surgery has been non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME PURCHASE - KNEE BRACE: 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), Treatment Index, 11th Edition (web), 2013, Knee - Criteria For Braces.

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

Decision rationale: CA MTUS states that a knee brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medial collateral ligament (MCL) instability although its benefits may be more emotional than medical. In this case, X-rays of both knees on unspecified date showed normal findings at the right knee, while left knee showed 2-3 millimeter medial joint space and 2 millimeters patellofemoral joint space. MRI of the left knee, dated 11/15/2008, revealed tears of medial meniscus involving the posterior horn and body. However, there is no available recent comprehensive physical examination of both knees. A report dated November 2012 cited that patient was recommended knee brace and crutches for ambulation. However, it is unclear if the patient received the durable medical equipment due to lack of documentation. Furthermore, an authorization for left knee replacement due to failed surgeries was sent on 10/08/2013. The utilization review report, dated 11/27/2013, cited that it was denied per referral summary. It is unclear if the request for knee brace is for post-operative use due to absence of its indication from the medical records submitted. In addition, the present request does not specify the laterality. Therefore, the request for DME purchase - knee brace is not medically necessary.

DME PURCHASE - WALKER: 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), Treatment Index, 11th Edition (web), 2013, Knee-Durable Medical Equipment (DME).

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 Section, Walking Aids.

Decision rationale: CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines, (ODG), Knee and Leg Section was

used instead. It states that walking aids are recommended to almost half of patients with knee pain. Frames or wheeled walkers are preferable for patients with bilateral disease. In this case, the patient only complained of left knee pain and imaging studies did not reveal remarkable findings for the contralateral knee. Furthermore, an authorization for left knee replacement due to failed surgeries was sent on 10/08/2013. The utilization review report, dated 11/27/2013, cited that it was denied per referral summary. It is unclear if the request for walker is for postoperative use due to absence of its indication from the medical records submitted. In addition, the present request does not specify the specific type of walker for purchase. Therefore, the request for DME purchase - walker is not medically necessary.

INJECTION - LOVENOX INJECTIONS X 14 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 (ODG), Treatment Index, 11th Edition (web), 2013, Knee And Leg - Venous Thrombosis.

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 Section, Rivaroxaban.

Decision rationale: CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines, (ODG), Knee and Leg Section was used instead. It states that prophylaxis for venous thromboembolism for at least 10 days after total knee arthroplasty is recommended and, oral anticoagulant regimen for use in an outpatient setting would be beneficial. In this case, an authorization for left knee replacement due to failed surgeries was sent on 10/08/2013. However, the utilization review report, dated 11/27/2013, cited that it was denied per referral summary. Since the requested surgery was deemed unnecessary, all of the associated services is likewise medically not necessary. Furthermore, the guidelines state that oral anticoagulation is superior than injectable medications such as enoxaparin (Lovenox). Therefore, the request for Injection - Lovenox Injections x 14 Days is not medically necessary.

HOME HEALTH CARE (BATHING, MEDICATION, WOUND CARE, WALKING) 3 HOURS A DAY/5 DAYS A WEEK/4 WEEKS: 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), Treatment Index, 11th Edition (web), 2013, Knee- Home Health Services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

Decision rationale: As stated on page 51 of CA MTUS Chronic Pain Medical Treatment Guidelines, home health services are only recommended for otherwise recommended medical treatment for patients who are homebound, generally up to no more than 35 hours per week.

Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. In this case, medical records submitted and reviewed do not provide a rationale for this request. There is likewise no comprehensive documentation regarding patient's activities of daily living and the extent of assistance needed that warrants the service of home health aide. Furthermore, since the requested left knee replacement was deemed unnecessary (based on utilization review report dated 11/27/2013), all of the associated services is likewise not medically necessary. Therefore, the request for Home Health Care (bathing, medication, wound care, walking) 3 hours a day/5 days a week/4 weeks is not medically necessary.

PRE-OPERATIVE MEDICAL CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation California Medical Treatment Utilization Schedule (MTUS) 2009, American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Second Edition (2004), Chapter 7, Page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Page 127.

Decision rationale: CA MTUS reference to ACOEM guidelines indicate that a consultation is used to aid diagnosis, prognosis, therapeutic management, determination of medical stability and permanent residual loss and/or examinee's fitness to return to work. In this case, the patient has been diagnosed with hypertension, dyslipidemia and pre-diabetes since 2010. Prescribed medications include Benicar and Atorvastatin. An authorization for left knee replacement due to failed surgeries was sent on 10/08/2013. However, the utilization review report, dated 11/27/2013, cited that it was denied per referral summary. Since the requested surgery was deemed unnecessary, all of the associated services is likewise medically not necessary. Therefore, the request for Preoperative Medical Clearance is not medically necessary.

**POST-OPERATIVE PHYSICAL THERAPY, 2 TIMES PER WEEK FOR 6 WEEKS:
Upheld**

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: As stated in the CA MTUS Post-Surgical Treatment Guidelines, accelerated perioperative care and rehabilitation intervention after knee arthroplasty reduced mean hospital length of stay. Recommendation is 24 visits over 10 weeks of physical therapy for postsurgical treatment of knee arthroplasty. In this case, an authorization for left knee replacement due to failed surgeries was sent on 10/08/2013. However, the utilization review report, dated 11/27/2013, cited that it was denied per referral summary. Since the requested surgery was

deemed unnecessary, all of the associated services is likewise medically not necessary. Therefore, the request for Postoperative Physical Therapy, 2 Times per week for 6 weeks is not medically necessary.