MAXIMUS Federal Services

Case Number:	CM14-0000123		
Date Assigned:	01/10/2014	Date of Injury:	06/08/2006
Decision Date:	08/21/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/31/2013

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 Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 55 year old male injured on 06/08/06. The clinical note dated 01/24/13 indicates the injury occurred when the injured worker fell while trimming trees and landed on both knees. The injured worker hyper extended both knees. The injured worker subsequently underwent a left knee replacement in 2009. A revision was completed in 2010. However, the note indicates the quadriceps muscle had completely detached 2 weeks after the revision. Two additional revisions were completed in 2011. The injured worker also underwent a manipulation under anesthesia. The clinical note dated 04/03/13 indicates the injured worker able to demonstrate full extension with 135 degrees of flexion. No strength deficits were identified at the left knee. The clinical note dated 10/31/13 indicates the injured worker showing significant range of motion deficits of 10 to 80 degrees at the left knee. +2 effusion was also identified. No instability was identified. The request for an in home RN for medication intake as well as evaluation and vital signs was denied as insufficient information had been submitted confirming any exceptional factors regarding the need for an in home RN. The utilization review dated 08/04/14 resulted in a partial approval. Additionally, the request for a 21 day rental for a cold therapy unit was modified to 7 days only.

IMR ISSUES, DECISIONS AND RATIONALES

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

In Home RN for Medication Intake, Vitals And Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, http://www.medicare.gov/Publications/Pubs/pdf/10969.pdf.

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

Decision rationale: The documentation indicates the injured worker demonstrating range of motion deficits at the left knee following an arthroplasty. No information has been submitted regarding the injured worker's current home status to indicate any additional family members living within the home. However, no information was submitted regarding the injured worker's need for a skilled nurse as medication intake, vital signs, and evaluations can be accomplished outside of skilled nursing. Therefore, the request for an in home RN to include the need for medication intake, vital signs, and evaluations is not medically necessary.

21 Day Cold Therapy Unit Rental: 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 Chapter, Continuous-flow cryotherapy units.

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 Chapter, Continuous cryotherapy.

Decision rationale: The previous utilization review resulted in a partial approval for a cold therapy unit for up to 7 days. Guidelines recommend a 7 day use of a cold therapy unit. Therefore, the request for an additional 21 days is not indicated. Therefore, this request is not indicated as medically necessary.