

<b>Case Number:</b>	CM14-0014224		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	07/01/1996
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	01/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2014

### 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 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 injured worker is a 60 year old claimant with an industrial injury date of 7/1/96 after a slip and fall on wet plastic under a deck. Injury is reported to the patient's right foot, back and leg. An exam note of 11/11/13 demonstrates bilateral leg spasms. The exam reports that falling has been persistent secondary to leg weakness. Objective findings are straight leg raise testing eliciting low back pain. The claimant is ambulating with a Moon Boot on left lower extremity. An exam note from 12/23/13 demonstrates continued low back pain and spasms. This note reports the claimant is ambulating with a crutch. Objective findings on exam demonstrate tenderness over left greater than right medial joint line.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **LEFT KNEE ULTRASOUND QTY: 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Knee & Leg (Acute & Chronic) page 56.

**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, Diagnostic ultrasound.

**Decision rationale:** The ODG recommends MRI as compared to ultrasound for soft tissue injuries. The cited notes do not demonstrate any evidence of soft tissue injury other than tenderness along the joint lines. Therefore the request is not medically necessary and appropriate.

**RIGHT KNEE ULTRASOUND QTY: 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Knee & Leg (Acute & Chronic) page 56.

**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, Diagnostic ultrasound.

**Decision rationale:** The ODG recommends MRI as compared to ultrasound for soft tissue injuries. The cited notes do not demonstrate any evidence of soft tissue injury other than tenderness along the joint lines. Therefore the request is not medically necessary and appropriate.

**RETROSPECTIVE BILATREAL KNEE WEIGHTBEARING X-RAYS QTY: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-342.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

**Decision rationale:** Per the ACOEM Guidelines, criteria for knee radiographs include inability to walk or weight bear, inability to flex knee to 90 degrees, joint effusion within 24 hours after direct blow or fall or tenderness over the fibular head or patella. In this case the notes from 12/23/13 do not demonstrate any of these criteria. There is no medical rationale given for the requested knee radiographs. As such, the request is not medically necessary and appropriate.

**CONTINUED HOME CARE ASSISTANCE 4 HOURS PER DAY (IN DAYS) QTY: 42:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, page 51, Home Health services are recommended only for medical treatment in patients who are home-bound on a part-time or intermittent basis. Medical treatment does not include homemaker services like

shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Home health skilled nursing is recommended for wound care or IV antibiotic administration. There is no evidence in the records from 12/23/13 or from 11/11/13 that the patient is home bound. While she ambulates with a cane there is no other medical reason why home health services are required. As such, the request is not medically necessary and appropriate.