

<b>Case Number:</b>	CM14-0014562		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	04/20/2009
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	01/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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 patient is a 73-year-old male with a 4/20/09 date of injury who underwent revision right total knee arthroplasty. A custom wheelchair, 2 pairs of TED hose stockings, 21-days of cold therapy unit rental, front wheel walker purchase, and nursing evaluation for medication intake and vitals were requested along with the surgery. Most recently, clinically there was varus deformity in the bilateral knees with mild effusion, painful range of motion, difficulty ambulating, and soft compartments. X-rays revealed no gross migration, loosening, or subsidence of the components. The most recent 12/10/13 progress note described x-rays that revealed varus malalignment of bilateral knees. It was noted that the patient has unstable bilateral knee replacement with malalignment and varus malalignment. A custom wheelchair was requested, as well as revision of right total knee replacement. Treatment to date has included physical therapy, lumbar surgery, bilateral knee steroid injection; bilateral total knee replacements; activity modification; wheelchair; walker; and medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CUSTOM WHEEL CHAIR:** 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 in Workers Comp.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Foot and Ankle Chapter.

**Decision rationale:** The requested custom wheelchair has not been found as medically necessary. The patient is utilizing a wheelchair, and it has not been clearly described why the current wheelchair is insufficient, requiring a custom wheelchair as necessary. ODG recommends a manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. This request is not substantiated.

**2 PAIRS TED HOSE STOCKINGS:** 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 in Workers Comp, Knee and Leg.

**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; compression garments.

**Decision rationale:** Medical necessity for 2 pairs of TED hose stockings has not been established. Although the patient was pending revision of right total knee arthroplasty, it was not discussed why two pairs of compression stockings were necessary. The request was partially certified for one pair of TED hose stockings. ODG supports the use of compression garments for deep vein thrombosis prophylaxis, however the need for 2 pairs of compression stockings remains unclear. Request is not medically necessary.

**21-DAY COLD THERAPY UNIT RENTAL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & leg chapter.

**Decision rationale:** Medical necessity for 21 days of cryotherapy unit rental is not established. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. As the request exceeds what guidelines deem as medically reasonable, 21-day cryotherapy rental unit is not substantiated.

**FRONT WHEEL WALKER PURCHASE:** 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 in Workers Comp, Knee and Leg, Walking Aids.

**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; walking aids. The Medicare National Coverage Determinations Manual, Mobility Assistive Equipment (MAE).

**Decision rationale:** The request for a front wheel walker is not established as medically necessary. ODG supports the use of walking aids when there are mobility deficits sufficient to impair participation in mobility related activities of daily living. However, the patient already has a walker, and there is no discussion regarding the need for second walker. The request is not medically necessary.

**IN HOME RN FOR EVALUATION, MEDICATION INTAKE AND VITALS:** Upheld

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

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

**Decision rationale:** Medical necessity for the requested home evaluation, medication intake, and vitals is not established. This request followed a request for revision total knee arthroplasty. However, the number of home health treatments/sessions was not specified. The request was modified for one home health evaluation with medication/vitals assessment. Guidelines support home health for those who are home bound and require medical treatment. However, the number of sessions requested has not been specified. The request cannot be substantiated without specifying the number of requested home health evaluations/treatments.