

Case Number:	CM14-0019295		
Date Assigned:	04/21/2014	Date of Injury:	11/19/2005
Decision Date:	07/02/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	02/14/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 69 year old female who reported an injury of unknown mechanism on 11/19/2005. In the clinical note dated 01/09/2014, the injured worker complained of low back pain and right knee pain which she rated at 7/10. The physical examination revealed the injured worker needed a cane for gait assistance, bilateral tenderness over the paraspinal musculature of the lumbar region, midline tenderness and muscle spasm over the thoracic and lumbar spine bilaterally. There was positive sciatic nerve compression and positive bilateral straight leg raise at 60 degrees in the supine and seated positions. The physical examination of the right knee revealed positive McMurray's test and positive Lachman instability. It was also documented that drawer's test and varus-valgus stress tests were positive bilaterally. Range of motion in both knees revealed extension at 0 degrees. The injured worker was status post revision left total knee arthroplasty 12/17/2012. She was considered temporarily totally disabled. The treatment plan included recommendations for aquatic therapy for the low back, continuation of prescribed medications, transdermal creams, right total knee arthroplasty, 3 day inpatient hospital stay, medical clearance, walker, cryotherapy machine, commode, Tens unit with conductive garment/supplies for 4 months, home physical therapy 3 times a week for 2 weeks and physical therapy post-operatively 2 times a week for 6 weeks. The request for authorization was submitted on 01/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

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).

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

Decision rationale: The Official Disability Guidelines (ODG) state that assistive devices for ambulation can reduce pain associated with osteoarthritis. Frames or wheeled walkers are preferable for patients with bilateral disease. Disability, pain, and age-related impairments seem to determine the need for a walking aid. The clinical notes documented that the injured worker was status post left knee arthroplasty using a cane and was recommended for right knee arthroplasty. It is unclear at this point if a walker would be needed for purchase and it was unclear if the injured worker is authorized for right knee arthroplasty along with physical therapy as it was recommended. The injured worker was also considered temporarily totally disabled. The requesting physician did not indicate whether the cane was insufficient for maintaining the injured worker's ambulatory ability. Therefore, the request for a walker for purchase is not medically necessary and appropriate.

3:1 COMMODE 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Durable medical equipment (DME).

Decision rationale: The request for 3:1 commode purchase is non-certified. The Official Disability Guidelines (ODG) state that most bathroom and toilet 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 and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. The ODG also states that durable medical equipment can withstand repeated use and could normally be rented and used by successive patients and is primarily and customarily used to serve a medical purpose. The request is for the purchase of a 3:1 commode and as stated by the guidelines, most bathroom and toilet supplies do not customarily serve a medical purpose. Therefore the request for a 3:1 is not medically necessary and appropriate.

TENS UNIT RENTAL FOR 4 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-116.

Decision rationale: The request for TENS unit rental for 4 months is non-certified. It appeared the TENS unit was being requested for post-operative use. The California MTUS guidelines state that TENS is recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery. Transcutaneous electrical nerve stimulation (TENS) appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. The guidelines also note that TENS is demonstrated to be of less or not all effective for other orthopedic surgical procedures. The request is for 4 months rental which would exceed the recommended guidelines for 30 days post-surgery. Therefore the request for TENS unit rental for 4 months is not medically necessary and appropriate.

TENS SUPPLIES PURCHASE FOR 4 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-116.

Decision rationale: The request for TENS supplies is non-certified. It appeared the TENS unit was being requested for post-operative use. The California MTUS guidelines state that TENS is recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery. Transcutaneous electrical nerve stimulation (TENS) appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. The guidelines also note that TENS is demonstrated to be of less or not all effective for other orthopedic surgical procedures. The request is for 4 months rental which would exceed the recommended guidelines for 30 days post-surgery. Additionally, the requested TENS unit is not indicated at this time. Therefore the request for TENS unit supplies purchase for 4 months is not medically necessary and appropriate.

MEDICAL CLEARANCE: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back pain, preoperative testing, general.

Decision rationale: The Official Disability Guidelines (ODG) state that preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided

by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgeries who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The clinical notes lack documentation of the injured worker having any other medical deficits or concerns that would necessitate a medical clearance. The injured worker was documented as status post left knee arthroplasty on 12/17/2012 with no noted issues or concerns. The guidelines state preoperative testing should be guided by the injured worker's clinical history, comorbidities, and physical examination findings. It was unclear what specific tests were being requested. Therefore, the request for medical clearance is not medically necessary and appropriate.