

Case Number:	CM14-0025199		
Date Assigned:	06/11/2014	Date of Injury:	10/13/1994
Decision Date:	07/15/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/27/2014

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, 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 60 year old male whose date of injury is 10/13/1994. He was stepping over a pipe on the floor when he slipped and landed on his left leg resulting in a hyperflexion injury to the left knee. Note dated 11/04/13 indicates that he subsequently underwent left knee arthroscopy. He is interested in obtaining bilateral knee replacements. Impression is severe bilateral knee tricompartmental osteoarthritis. Office visit note dated 01/30/14 indicates that the left knee is more painful than the right. The injured worker as subsequently authorized to undergo left knee arthroplasty with 3 day inpatient stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

INPATIENT ACUTE REHAB STAY VS. SNF PLACEMENT FOR TWO (2) WEEKS S/P LEFT TOTAL KNEE REPLACEMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Skilled nursing facility (SNF) care.

Decision rationale: Based on the clinical information provided, the request for inpatient acute rehab stay vs SNF placement for two weeks status post left knee replacement is not medically necessary. The injured worker has been authorized to undergo left knee replacement. The submitted records fail to establish the presence of postoperative complications that would require this level of treatment. There is no documented need for around the clock skilled care. There is no clear rationale provided to support the request, and the request is not medically necessary in accordance with Official Disability Guidelines recommendations.

HOME HEALTH AIDE 4-6 HOURS PER DAY FOR TWO WEEKS S/P LEFT TOTAL KNEE REPLACEMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Based on the clinical information provided, the request for home health aide 4-6 hours per day for two weeks is not recommended as medically necessary. The Chronic Pain Medical Treatment Guidelines support home health services for injured workers who are homebound on a part-time or intermittent basis. The submitted records fail to establish that this injured worker is homebound on a part-time or intermittent basis. There is no current, detailed physical examination or home health assessment submitted for review. Therefore, the request cannot be deemed as medically necessary.

HOME PHYSICAL THERAPY THREE (3) TIMES A WEEK FOR THREE (3) WEEKS AFTER DISCHARGE FROM HOSPITAL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Based on the clinical information provided, the request for home physical therapy 3 times a week for 3 weeks after discharge from hospital is not recommended as medically necessary. The Chronic Pain Medical Treatment Guidelines support home health services for injured workers who are homebound on a part-time or intermittent basis. The submitted records fail to establish that this injured worker is homebound on a part-time or intermittent basis. There is no current, detailed physical examination or home health assessment submitted for review. Therefore, the request cannot be deemed as medically necessary.