

Case Number:	CM14-0030680		
Date Assigned:	08/01/2014	Date of Injury:	10/14/1998
Decision Date:	12/15/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/10/2014

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:

This 70-year-old male sustained an industrial injury on 10/14/1998. The mechanism of injury was not documented. The patient had a long-standing history of bilateral knee and left hip pain relative to this injury. Past surgical history was positive for left total hip replacement. The 2/7/14 treating physician report indicated that the patient was last seen in August 2013. He reported a progressive deterioration of both knees over the prior 6 months. He was frustrated with his current status. Conservative treatment had included medications, injections, physical therapy, and bracing, but the knees were increasingly painful and limited. Functional limitations were documented in activities of daily living and recreational activities. Physical exam documented antalgic gait, valgus deformity of 10-15 degrees, flexion deformity 5-10 degrees, and further flexion to 115 degrees. There was lateral compartment crepitus and discomfort. X-rays showed a 45-degree flexed coronal plane angle with bone on bone contact in the lateral compartment, and further evidence of tricompartmental disease. The treatment plan recommended staged bilateral total knee arthroplasties, the right knee first. The 2/24/14 utilization review certified a request for right and left total knee arthroplasties to be staged 4 to 5 weeks apart. Additional certifications were noted for 2 day inpatient stay, one unit of autologous blood for each knee, pre-ops clearance, front wheeled walker, out-patient physical therapy 3x4, Norco 10/325 #100, Meloxicam 15 mg #30, and Lovenox 40 mg #10. The requests for crutches, 3 in 1 commode, home health aide and inpatient rehab or skilled nursing placement for 2 weeks were denied. The requests for continuous passive motion and cold therapy units, and home health physical therapy were partially certified. A right total knee arthroplasty was subsequently performed on 4/2/14, followed by discharge home on 4/4/14 without complications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Physical Therapy 3x/Week for 3/Weeks (9 Visits): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51, Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: The California MTUS recommends home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis. Post-Surgical Treatment Guidelines for knee arthroplasty suggest a general course of 24 post-operative visits over 10 weeks during the 4-month post-surgical treatment period. The 2/24/14 utilization review modified the request for home health physical therapy 3x3 to 3x2 as supported by guidelines for 2 weeks of initial home care and transition to out-patient treatment. Additional out-patient physical therapy was certified for 12 visits. There is no compelling rationale to support the need for in home physical therapy longer than 2 weeks. Therefore, this request is not medically necessary.

Crutches (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, Knee and Leg Procedure Summary, 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, Walking aids (canes, crutches, braces, orthoses, & walkers)

Decision rationale: The California MTUS guidelines do not provide specific guidelines for post-op ambulatory assistive devices. The Official Disability Guidelines state that disability, pain, and age-related impairments determine the need for a walking aid. Assistive devices can reduce pain and allow for functional mobility. The 2/24/14 utilization review denied the request for purchase of crutches as a front wheeled walker had been certified and the need for multiple assistive devices was not evident. There was no compelling rationale presented to support the need for an additional walking aide beyond the front wheeled walker previously certified. Therefore, this request is not medically necessary.

Continuous Passive Motion (CPM) (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, Knee and Leg Procedure Summary, Continuous Passive Motion Devices

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, Continuous passive motion (CPM)

Decision rationale: The California MTUS does not provide recommendations for this device following total knee replacement. The Official Disability Guidelines state that the use of a continuous passive motion device may be considered medically necessary in the acute hospital setting for 4 to 10 day (no more than 21 days) following total knee replacement and for home use up to 17 days while the patient at risk of a stiff knee is immobile or unable to bear weight following a primary or revision total knee arthroplasty. The 2/24/14 utilization review modified the request for purchase of a continuous passive motion (CPM) device to 21 days rental of a CPM device following each procedure consistent with guidelines. There is no compelling reason in the records reviewed to support the medical necessity of a CPM device beyond 21-day rental following each procedure as previously certified. Therefore, this request is not medically necessary.

Cold Therapy Unit (CTU) x 14 Days (Rental): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Procedure Summary, Continuous Flow Cryotherapy

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, Continuous flow cryotherapy

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following knee surgery. The 2/24/14 utilization review modified the request for 14-day rental of a cold therapy unit to 7 days rental following each procedure consistent with guidelines. There is no compelling reason in the records reviewed to support the medical necessity of a cold therapy unit beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

3 in 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, Knee and Leg Procedure Summary, Durable Medical Equipment (DME)

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, Bathtub seats

Decision rationale: The California MTUS is silent regarding this durable medical equipment. The Official Disability Guidelines state that certain DME toilet items (commodes) are medically

necessary if the patient is room-confined or when prescribed as part of a medical treatment plan for injury or conditions that result in physical limitations. Bathtub seats are considered a comfort or convenience item, hygienic equipment, & not primarily medical in nature. There is no indication that the patient will be room confined following hospital discharge from a total knee replacement to support the medical necessity of a bedside commode. A shower chair is considered a comfort or convenience item. Therefore, this request is not medically necessary.

Home Health Aide 4-6 Hours/Day x 2 Weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Procedure Summary

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

Decision rationale: The California MTUS recommends home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis, generally no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Guideline criteria have not been met. There is no clear rationale to support the medical necessity of a home health aide for up to 42 hours per week. Therefore, this request is not medically necessary.

Inpatient Acute Rehab Stay vs. Skilled Nursing Facility (SNF) Placement x 2 Weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Medicine Treatment, Skilled Nursing Facility

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, Rehab, inpatient, Skilled nursing facility (SNF) care, Skilled nursing facility LOS (SNF)

Decision rationale: The California MTUS does not provide recommendations for inpatient acute rehabilitation or skilled nursing facility (SNF) stay following total knee arthroplasty. The Official Disability Guidelines provide specific indications for inpatient rehabilitative and skilled nursing care. Criteria include the patient was hospitalized for at least 3 days and there are significant post-operative functional limitations or associated significant medical comorbidities that preclude management with lower levels of care. The 2/24/14 utilization review denied the request for inpatient acute rehab stay versus SNF placement for 2 weeks as there was limited evidence of complicating factors that would warrant pre-authorization of admission to inpatient rehab or a skilled nursing facility prior to post-operative assessment of function. There is no compelling rationale to support the medical necessity of either an inpatient acute rehabilitation or SNF stay relative to functional limitations or co-morbidities. Records indicated the patient was

successfully discharged to home after a 2 day hospital stay. Therefore, this request is not medically necessary.