

Case Number:	CM14-0040832		
Date Assigned:	06/27/2014	Date of Injury:	07/09/2003
Decision Date:	08/11/2014	UR Denial Date:	03/19/2014
Priority:	Standard	Application Received:	04/04/2014

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 Physical Medicine and Rehabilitation 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 58 year-old patient sustained a left knee injury on 7/9/2003 while employed by [REDACTED]. The patient is s/p left total knee arthroplasty on 2/22/10 and lumbar decompression and fusion at L4-S1 in October 2012. A report of 8/29//13 noted the patient with low back pain radiating to bilateral lower extremities; neck pain radiating to the bilateral upper extremities and left lower extremity pain rated at 7-8/10 with medications and 10/10 without medications. The patient noted limitations with activities of daily living. Exam showed antalgic gait; use of cane; lumbar range with pain; lumbar tenderness; limited cervical range secondary to pain with tenderness at C4-7; myofascial tenderness of lumbar and cervical areas; sensory and motor had no change. Treatment included medication refills (Percocet, Tramadol, Vitamin D, Senokot, Gabapentin), a urine drug screen, and ongoing exercise program. A report of 2/14/14 from the provider noted the patient with chronic ongoing bilateral knee pain. X-rays showed cementless knee arthroplasty with satisfactory fixation, and patellar tilt in varus alignment without documented loosening. Exam showed no erythema; mild swelling; well-healed incision; range of knee of 0-115 degrees with motor strength of 4+/5. Treatment noted failure of conservative care and revision arthroplasty was recommended for mechanical problem with valgus instability. Request(s) for Post-op Home Health PT - 3x2 = 6 sessions was non-certified on 3/19/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op Home Health PT - 3x2 = 6 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 52.

Decision rationale: The MTUS Chronic Pain Guidelines support home health therapy for patients who are homebound requiring intermittent home therapy and do not include homemaker services such as cleaning, laundry, and personal care. The patient does not meet any of the criteria to support this treatment request and medical necessity has not been established. Submitted reports have not adequately addressed the indication or demonstrated the necessity for home health PT. There is no documentation that the patient is homebound as the patient attends regular office visits, ambulating with use of cane, or what specific deficient performance is evident in activities of daily living. Exam indicated tenderness and decreased range of motion. There are no clear neurological deficits noted within the medical records provided for review. The request is not medically necessary and appropriate.