

Case Number:	CM14-0061446		
Date Assigned:	07/14/2014	Date of Injury:	03/07/1996
Decision Date:	09/23/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	05/02/2014

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 Surgeon and is licensed to practice in Texas and Colorado. 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 65-year-old male who reported an injury on 03/07/1996. The mechanism of injury was not specifically stated. Current diagnoses include below-the-knee amputation and painful hardware arthrosis. The injured worker was evaluated on 02/19/2014 with ongoing pain in the medial joint line of the left knee. The patient is noted to have undergone a right below-the-knee amputation and multiple surgeries to the left knee. Previous conservative treatment is noted to include physical therapy and medication. The injured worker was noted to be status post total knee revision of the left knee on 12/20/2012. Physical examination revealed negative swelling or effusion, 0 to 95 degree range of motion, medial laxity, and no drainage or evidence of infection. The injured worker was currently utilizing a brace and a cane. X-rays of the left knee joint obtained in the office on that date indicated no signs of loosening or calcium deposits or loose bodies. It is noted that the injured worker was recently fitted with a below-the-knee amputation prosthesis on the right. Treatment recommendations included an electric scooter. A Request for Authorization form was then submitted on 03/28/2014 for an electric scooter, a new socket prosthetic, revision of the total knee arthroplasty on the left, and home health care postoperatively.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME purchase: Electric scooter: 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 under the heading of power mobility devices.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 99.

Decision rationale: The California MTUS Guidelines do not recommend power mobility devices if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair. There is no mention of a contraindication to a cane or a walker. There is no mention of insufficient upper extremity function to propel a manual wheelchair. There is also no indication that this injured worker does not maintain assistance from a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. As the medical necessity has not been established, the request for DME purchase: Electric scooter is not medically appropriate.

New socket prosthetic: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

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

Decision rationale: The Official Disability Guidelines state a lower limb prosthesis may be considered medically necessary when the patient will reach or maintain a defined functional state within a reasonable period of time, the patient is motivated to ambulate, and the prosthesis is furnished incident to a physician's services or a physician's order. The patient is noted to have undergone a right below-the-knee amputation. However, it is also noted that the patient was recently fitted with a new prosthesis circuit. Therefore, the medical necessity for an additional prosthesis has not been established. As such, the request for New socket prosthetic is not medically appropriate.

Revision of total left knee arthroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Revision total knee arthroplasty.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have activity limitation for more than 1 month and failure of exercise programs. The Official Disability Guidelines recommend a revision of a total knee arthroplasty for recurrent disabling pain, stiffness, and functional

limitation that has not responded to appropriate conservative nonsurgical management. There should be documentation of a fracture or dislocation of the patella, instability of the components, or a septic loosening, infection, or periprosthetic fractures. The injured worker does not currently meet criteria for the requested procedure. It is currently unknown whether there is a deficit in flexion/extension, and there is no documentation of medial instability. X-rays obtained in the office on the requesting date indicated no evidence of loosening or calcium bodies, or loose bodies. The medical necessity has not been established. Therefore, the request for Revision of total left knee arthroplasty is not medically appropriate.

Home healthcare postoperatively: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment section for knee and leg under the heading of home healthcare services.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.