

Case Number:	CM14-0206161		
Date Assigned:	12/18/2014	Date of Injury:	09/26/2008
Decision Date:	03/06/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/09/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 patient is a 75 year old female with an injury date of 09/26/08. Based on the 12/10/14 progress report provided by treating physician, the patient is status post right total knee replacement 11/05/14, and complains of knee and back pain. Patient has severely antalgic gait and ambulates with 2 canes. Physical examination to the right knee on 12/10/14 revealed incision healing well and significant medial knee pain to palpation, and with hyperflexion. Range of motion was decreased, 0-105 degrees. Patient had postoperative physical and occupational therapy. Patient's medications include Pantoprazole, MSM, Latanoprost, Celebrex, Dilaudid, and Oxycontin. Per treater report dated 07/22/14, the patient is a widow living alone, and has a daughter who is having back surgery. Diagnosis 07/22/14, 12/10/14- Primary localized osteoarthritis, lower leg- Pain in joint, lower leg The utilization review determination being challenged is dated 12/02/14. Treatment reports were provided from 07/15/14 - 12/10/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health PT/OT and a registered nurse (RN): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter

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

Decision rationale: The patient is status post right total knee replacement 11/05/14, and complains of knee and back pain. The request is for HOME HEALTH PT/OT AND A REGISTERED NURSE (RN). Patient's diagnosis on 12/10/14 included primary localized osteoarthritis of the lower leg and pain in the lower leg joint. Physical examination to the right knee on 12/10/14 revealed incision healing well and significant medial knee pain to palpation, and with hyperflexion. Range of motion was decreased, 0-105 degrees. Patient had postoperative physical and occupational therapy. Patient's medications include Pantoprazole, MSM, Latanoprost, Celebrex, Dilaudid, and Oxycontin. Per treater report dated 07/22/14, the patient is a widow living alone, and has a daughter who is having back surgery. The MTUS page 51 has the following regarding home services, "Recommended only for otherwise recommended medical treatment for patients who are home-bound on a part-time or intermittent basis generally up to 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." For PT/OT, MTUS recommends 8-10 sessions for myalgia, myositis, neuralgia type of problems. Treater has not provided reason for the request. Treater does not specify any rationale for home assistance, such as danger to self, or others, inability to transfer, etc. No explanation is provided as to why an RN is needed for home care. Patient has severely antalgic gait and ambulates with 2 canes but the treater has not discussed patient's ability to perform self-care and ADL's. There are no discussions regarding the patient's specific functional needs that would require assistance and the medical justification for the deficits. Finally, there is no duration to the requested PT/OT and an RN. Therefore, the request IS NOT medically necessary.

DME (unspecified): 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) Chapter Knee & Leg, DME

Decision rationale: The patient is status post right total knee replacement 11/05/14, and complains of knee and back pain. The request is for DME. Patient's diagnosis on 12/10/14 included primary localized osteoarthritis of the lower leg and pain in the lower leg joint. Physical examination to the right knee on 12/10/14 revealed incision healing well and significant medial knee pain to palpation, and with hyperflexion. Range of motion was decreased, 0-105 degrees. Patient had postoperative physical and occupational therapy. Patient's medications include Pantoprazole, MSM, Latanoprost, Celebrex, Dilaudid, and Oxycontin. Per treater report

dated 07/22/14, the patient is a widow living alone, and has a daughter who is having back surgery. ODG guidelines, Chapter 'Knee & Leg' and Title 'DME', states that "The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. (CMS, 2005)" DME is "Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below." Treater has not provided reason for the request, nor discussed DME being requested. The request in this case is too generic and might conceivably refer to any number of medical conditions and guideline citations. Medical necessity for the request cannot be established, therefore the request IS NOT medically appropriate.