

Case Number:	CM14-0038524		
Date Assigned:	06/27/2014	Date of Injury:	04/06/2010
Decision Date:	01/02/2015	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	04/02/2014

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 Surgery and is licensed to practice in Minnesota. 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 44 year old male with a history of work related injury to his left knee on 04/06/2010. He underwent arthroscopies of the left knee on 05/19/2010 and 1/6/2011. In light of persisting pain and evidence of osteoarthritis on imaging studies, he underwent a unicompartmental knee arthroplasty on 7/19/2012. The documentation indicates that the tibial component was undersized and subsidence took place necessitating a total knee arthroplasty despite his relatively young age. The documentation also indicates a chronic pain syndrome. He has been certified for a left total knee arthroplasty. The disputed issues include home health therapy three times per week for two weeks and Polar care for purchase. Utilization review non-certified home health therapy and also non-certified Polar care purchase citing guidelines. However, rental of a continuous flow cryotherapy machine was certified for 7 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health physical therapy three (3) times per week for two (2) weeks: 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): 51.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommend home health services for otherwise recommended medical treatment for patients who are homebound on a part time basis. Medical treatment does not include housekeeping or personal care services. After hospital discharge an in-patient rehab facility has been certified for one week. At that point the injured worker should be independent with ambulation and should not be homebound. Therefore, Home health therapy is not medically necessary per MTUS guidelines.

Polar care for 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- Treatment in Worker's Compensation; ODG Treatment: Integrated Treatment/Disability Duration Guidelines

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

Decision rationale: The California MTUS guidelines do not address this issue. Official Disability Guidelines recommend use of continuous flow cryotherapy post-operatively after knee surgery for 7 days. It reduces swelling, inflammation, and pain, and reduces the need for narcotics post-operatively. Rental for 7 days has been certified by UR and the requested purchase of a Polar care unit is not medically necessary per the Official Disability Guidelines.