

Case Number:	CM15-0001897		
Date Assigned:	01/12/2015	Date of Injury:	07/23/2013
Decision Date:	04/01/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	01/05/2015

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: Orthopedic Surgery, Sports Medicine

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 61-year-old male who reported an injury on 07/23/2013 due to an unspecified mechanism of injury. On 11/02/2014, he presented for a followup evaluation. It was noted that treatment requested was a right total knee replacement and Norco 5/325 mg #30. He reported pain rated at a 9/10 made better by rest and worse by prolonged walking and standing. The quality of pain was described as dull, aching, stabbing and sharp. A physical examination showed that he was in no acute distress with right knee range of motion of 5 degrees to 120 degrees and 1+ effusion. There was also positive medial joint line tenderness. Sensation, motor strength and deep tendon reflexes were intact. He was diagnosed with right knee medial compartment degenerative disc disease with industrial aggravation. The treatment plan was for a right total knee replacement with transportation for medical care, skilled nursing facility for postoperative care, use of walker and bedside commode, cold therapy and continuous passive motion machine, and postoperative pain medications and anticoagulation medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transportation: Upheld

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

Decision rationale: The Official Disability Guidelines recommend transportation to and from office visits in the same community for those with disabilities preventing them from self transport. While it is noted that the injured worker has pain in the right knee, there was a lack of documentation showing that he would not be able to transport himself to and from office visits. Also, there was a lack of documentation showing that the injured worker does not have anybody to transport him to and from visits. Furthermore, a clear rationale for the medical necessity of the request was not stated. Therefore, the request is not supported. As such, the request is not medically necessary.

Skilled nursing facility x14 days: Upheld

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

Decision rationale: The Official Disability Guidelines state that skilled nursing facility care is recommended if necessary after hospitalization when the injured worker requires skilled nursing or skilled rehabilitation services on a 24 hour basis. While it was noted that a right knee surgery, there was a lack of documentation indicating that the injured worker requires 24 hour skilled nursing or skilled rehabilitation services to support the request. Without this information, the request would not be supported. Therefore, the request is not medically necessary.

Cold therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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 and Leg, Continuous flow cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery for up to 7 days. While cold therapy is considered following the proposed procedure, there was a lack of documentation indicating how long the cold therapy unit was being requested for. Without this information, the request would not be supported. Therefore, the request is not medically necessary.

CPM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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 and Leg, Continuous Passive Motion.

Decision rationale: The Official Disability Guidelines state that continuous passive motion devices are recommended for in hospital use or for home use in patients at risk of a stiff knee based on demonstrated compliance and measured improvements. While the continuous passive motion machine is considered, there is a lack of documentation showing how long the continuous passive motion machine was being requested for. The number of days was not stated within the request and the body part being used for was also not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

Post operative pain medication: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78.

Decision rationale: The request for postoperative pain medication is not supported. The California MTUS Guidelines state that opioids are used in the treatment of chronic pain. Also, there should be an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The documentation provided indicates that the injured worker may have been taking pain medications prior to the request for a surgical intervention. Without documentation regarding his response to treatment and urine drug screen/CURES report showing that he has been compliant with his medication regimen, this request would not be supported. Also, the medication, dosage, frequency, and quantity of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.