MAXIMUS Federal Services

Case Number:	CM15-0002784		
Date Assigned:	01/13/2015	Date of Injury:	08/16/2013
Decision Date:	03/13/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/06/2015

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 60-year-old male who reported an injury on 12/02/2013 due to cumulative trauma. On 08/18/2014, the injured worker presented for a followup with complaints of posterior neck pain, right shoulder pain, low back pain, left knee and calf pain, and right ankle pain. The examination of the cervical spine revealed a positive right shoulder impingement sign and crepitus over the right shoulder. The examination of the bilateral wrists revealed positive bilateral Phalen's and Tinel's signs and 5/5 strength in the bilateral upper extremities with intact sensation to light touch and pinprick. The examination of the lumbar spine noted decreased range of motion with a negative bilateral straight leg raise. There was a positive right sided Faber's sign. The diagnoses were degenerative joint disease of the left knee with chronic flexion contracture, an anterior cruciate ligament tear with degenerative posterior horn of the medial meniscus, and a grade 3 tear of the anterolateral aspect of the lateral meniscus with hypertrophic spurring of the medial and lateral compartments of the left knee; low back strain; right shoulder impingement syndrome; right cervical strain; right carpal tunnel syndrome; left carpal tunnel syndrome; and sleep disturbance. Prior therapies were not provided. The provider recommended a surgical service inpatient stay and a postoperative DME cold therapy unit. There was no rationale provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: In-patient stay (unspecified duration): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment index, 12 Edition (web), 2014, Knee & Leg, Hospital length of stay (LOS)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Hospital Length of Stay.

Decision rationale: The request for an associated surgical service: inpatient stay (unspecified duration) is not medically necessary. The Official Disability Guidelines recommend a median length of stay based on the type of surgery. There is no information on the type of surgical services recommended. Additionally, the provider's request as submitted does not specify a duration of time for the inpatient stay. As such, medical necessity has not been established.

Associated surgical service: Post-op DME Cold Therapy Unit (no duration given): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment index, 12 Edition (web), 2014, Knee & Leg, continuous flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Associated surgical service: Post-op DME Cold Therapy Unit (no duration given).

Decision rationale: The request for associated surgical service: postop DME cold therapy unit (no duration given) is not medically necessary. The Official Disability Guidelines recommend cold therapy units for 7 days including home use. The provider's request for a DME cold therapy unit does not indicate the site at which the cold therapy unit was indicated for and whether the cold therapy unit was to be purchased or rented in the request as submitted. As such, medical necessity has not been established.