MAXIMUS Federal Services

Case Number:	CM15-0003138		
Date Assigned:	01/14/2015	Date of Injury:	03/30/2001
Decision Date:	03/19/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/07/2015

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: New York
Certification(s)/Specialty: Neurological Surgery

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 59 year old male, who sustained an industrial injury on 3/30/2001. The current diagnoses are end-stage osteoarthritis and status post arthroscopy of the right knee (7/24/2008). Currently, the injured worker complains of constant pain with popping and giving out to both knees. He reports locking while walking with severe pain. Treatment to date has included medications, physical therapy, injections, and surgery. The treating physician is requesting inpatient (unknown number of days) for right total knee replacement, post-op continuous passive motion rental X6 weeks, cooling unit rental x6 weeks, in-home dressing changes 3-5 times/week x3 weeks by visiting nurse, home physical therapy 3 times a week for 3-5 weeks to the right knee, home health RN X21, Hydrocodone/APAP/Ondansetron 1000/2mg #60, Flurbiprofen/Omeprazole 100mg/10mg #90, diagnostic test - lab, Ultram 50mg #200, MRI of the right knee, Lunesta 1mg #90, and retrospective IM Ketorolac 60mg/Xylocaine 1mn (DOS6/10/2014), which is now under review. On 12/30/2014, Utilization Review had non-certified a request for inpatient (unknown number of days) for right total knee replacement, post-op continuous passive motion rental X6 weeks, cooling unit rental x6 weeks, in-home dressing changes 3-5 times/week x3 weeks by visiting nurse, home physical therapy 3 times a week for 3-5 weeks to the right knee, home health RN X21, Hydrocodone/APAP/Ondansetron 1000/2mg #60, Flurbiprofen/Omeprazole 100mg/10mg #90, diagnostic test - lab, Ultram 50mg #200, MRI of the right knee, Lunesta 1mg #90, and retrospective IM Ketorolac 60mg/Xylocaine 1mn (DOS6/10/2014). The California MTUS, Postsurgical, and Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op DME Rental: Continuous Passive Motion x6 weeks: 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), Knee & Leg, Continuous passive motion (CPM)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Replacement Chapter-Continuous passive motion

Decision rationale: ODG guidelines indicate post-operative use of the continuous passive motion assisted device is recommended either in hospital or at home up to 17 days for restoration of range of motion. The request for rental up to six weeks exceeds the guidelines. Therefore this requested service is not medically necessary or appropriate.

Post-op DME Rental: Cooling Unit x6 weeks: 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), 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, Knee Replacement Chapter-Continuous flow cryotherapy

Decision rationale: ODG guidelines recommend continuous flow cryotherapy postoperatively up to seven days. This would be the expected time in which the worker would have difficulty bearing weight or decreased mobility. The request exceeds guidelines in which the expected restoration of function following a total arthroplasty would take place. Thus this request is not medically necessary or appropriate.

Post-op In-home dressing changes 3 to 5 times a week for 3 weeks by a visiting nurse: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee Replacement- Home Health Services

Decision rationale: Post-op in-Home dressing changes 3-5 times a week for 3 weeks by a visiting nurse would be recommended under ODG guidelines were this medical treatment

necessary. No evidence is provided that this frequency would be normal in the usual post-op period for a knee arthroplasty. The usual in-hospital length of stay of 3 days would have allowed time for early dressing changes and the wound is expected to be dry by the time of discharge. This request exceeds guidelines and thus is not medically necessary or appropriate.

Home Physical therapy 3 times for 3-5 weeks to the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51,Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Chapter Physical Medicine-

Decision rationale: ODG guidelines note that functional exercises after hospital discharge for total knee arthroplasty result in small to moderate short-term gains. They recommend up to 24 visits over 10 weeks. The requested associated surgical service of home physical therapy 3 times for 3-5 weeks does not comply with these guidelines. Thus the requested service is not medically necessary or appropriate.

Facility: Inpatient stay, unknown # of days for a right total knee replacement: 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), 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, Knee replacement Chapter-Hospital length of stay

Decision rationale: According to the ODG guidelines the median length of stay is three days for a total knee replacement. The median length of stay is 3.4 days. This request is for an unknown number of days for a knee replacement which is outside of guidelines. Thus this request for Facility, inpatient stay, unknown # of days for a right total knee replacement is not appropriate or medically necessary.

Ultram 50mg, #200: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 84 and 94.

Decision rationale: Tramadol (Ultram) according to the California MTUS guidelines is a synthetic opioid affecting the central nervous system. It can increase the risk of seizures in

patients taking other opioids which this worker has been prescribed. It also can interact with ondansetron which the worker has been prescribed. The dosing recommendations is to begin titrating the patient up from 100mg/day of ultram. Documentation is not furnished that such titration is planned. Moreover, the amount of tablets exceeds the recommendation for a 30 day daily dosage schedule. Thus the request for Ultram 50mg, #200 is not appropriate or medically necessary.

MRI (magnetic resonance imaging) of the right knee for patient specific knee instrumentation protocol (Zimmer): 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), Knee & Leg, Custom fit total knee (CFTK) replacement

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Chapter-Custom fit total knee (CFTK) replacement

Decision rationale: ODG guidelines indicate the MRI imaging for patient specific knee instrumentation protocol helps determine the correct implant size and placement but it costs more and causes delay in scheduling but may save time and some patients report faster recovery. However, the guidelines indicate it is under study, awaiting higher quality trials. Thus the request for MRI (magnetic resonance imaging) of the right knee for patient specific knee instrumentation protocol is not appropriate or medically necessary.

Post-op Home Health RN x21: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

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

Decision rationale: The California MTUS guidelines indicate that home health services are recommended for medical treatment for those patients who are home bound. The reason for the worker's operation was to restore functionality not to cause him to be homebound. Moreover, documentation does not show co-morbid conditions which would need medical treatment. Thus the request for Post-op Home Health RN x21 is not appropriate or medically necessary.

Post-op Hydrocodone/APAP/Ondansetron 1000/2mg, #90 with 3 refills: 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), Pain, Antiemetics (for opioid nausea)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter-Anti emetics

Decision rationale: The combination of the opioid hyrdocodone with the serotonin 5 HT3 receptor antagonist ondansetron (Zofran) which is anti-emetic goes against the ODG guidelines recommendations. The FDA approved ondansetron in the treatment of nausea and vomiting associated with chemotherapy and radiation not in the treatment of the nausea from opioid use. The prescription of 1000 mg of acetaminophen would allow the worker to ingest amounts that could lead to hepatic problems. Moreover, the use of this medication with the prescribed Ultram could increase the risks of seizures. Therefore the request for Post-op hydrocodone/APAP/Ondansetron 1000/2mg. # 90 with 3 refills is not medically necessary or appropriate.

Post-op Flurbiprofen/Omeprazole 100mg/10mg, #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The California MTUS guidelines note that if the patient is at intermediate risk for gastrointestinal events and there is no cardiovascular disease then the use of a NSAID with a proton pump inhibitor would be recommended. Documentation does not give evidence of intermediate risk in this worker. Thus this request is not medically necessary or appropriate.

Diagnostic test - Lab, Other: 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), Low Back, Preoperative lab testing

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Therapy Chapter-Preoperative lab testing

Decision rationale: The ODG guidelines recommend preoperative tests should be guided by the patient's clinical history, comorbidities and physical examination findings. Documentation does not support this was done. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach. Explanation of what routine tests have been selected is not seen in the documentation nor how the approach will be modified. Thus this request is not medically necessary or appropriate.

Post-op Lunesta 1mg #90 with 3 refills: 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), Pain, Insomnia treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter-insomnia treatment

Decision rationale: The ODG guidelines indicate that the non-benzodiazepine sedative-hypnotic eszopicolone (lunesta) is a first line medication for insomnia. Its dosage recommendation of one to two mg to aid in falling asleep would mean that this request exceeds the guidelines in the number of# 90 with 3 refills. Documentation does not characterize the worker's specific sleep problem. Thus this request is not medically necessary or appropriate.

Retrospective request for IM Ketorolac 60mg/Xylocaine 1ml given 06/10/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Ketorolac

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketorolac(Toradol) Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter-Ketorolac (Toradol)

Decision rationale: According to California MTUS guidelines ketorolac is not to be used for minor or chronic painful conditions. Since this worker's pain has been chronic using this injection is not following the guidelines. The ODG guidelines indicate this NSAID can be recommended as an option to corticosteroid injections which the injured worker had already been administered in the form of depomedrol. Thus this request is not medically necessary or appropriate.