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| Case Number: | CM15-0003839 | | |
| Date Assigned: | 01/14/2015 | Date of Injury: | 09/18/2011 |
| Decision Date: | 03/23/2015 | UR Denial Date: | 01/04/2015 |
| Priority: | Standard | Application Received: | 01/08/2015 |

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, Arizona
 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 injured worker is a 61-year-old female who reported an injury on 09/18/2001. The mechanism of injury was repetitive use. Her diagnosis was noted as severe left knee osteoarthritis. Her past treatments were noted to include acupuncture therapy, TENS unit, medication, injections, surgery, and physical therapy. Her diagnostic studies were noted to include an official MRI of the lumbar spine performed on 05/29/2013. Her surgical history was noted to include partial medial meniscectomy, partial lateral meniscectomy, and medial femoral chondroplasty of the right knee performed on 11/08/2002 and partial medial meniscectomy and medial femoral chondroplasty of the left knee performed on 05/05/2003. During the assessment on 01/09/2015, the injured worker complained of severe neck pain with headaches. She indicated that the pain radiated to the bilateral shoulders with numbness and tingling that also radiated to the bilateral wrists. She rated the pain a 7/10. The physical examination revealed tenderness to palpation of the lumbar spine with decreased range of motion, with spasm. There was a positive straight leg raise bilaterally. The injured worker's current medication list was not provided. The treatment plan and rationale was not provided. The Request for Authorization form was dated 12/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health care 3x1: Upheld

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

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

Decision rationale: The request for home health care 3x1 is not medically necessary. The California MTUS Guidelines recommend home health service 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. The clinical documentation did not indicate that the injured worker was considered home bound. The rationale for the request was not provided. Given the above, the request is not medically necessary.

Venapro/DVT device: 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 Chapter, Venous Thrombosis Section

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

Decision rationale: The request for Venapro/DVT device is not medically necessary. The Official Disability Guidelines recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anti coagulation therapy. Minor injuries in the leg are associated with greater risk of venous thrombosis. The clinical documentation did not indicate that the patient was at high risk of developing venous thrombosis or was being considered for anti coagulation therapy. The rationale for the request was not provided. Given the above, the request is not medically necessary.

Cold therapy unit: 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 Chapter, Continuous-Flow Cryotherapy Section

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

Decision rationale: The request for cold therapy unit is not medically necessary. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery.

Postoperative use generally may be up to 7 days, including home use. The clinical documentation did not indicate that the injured worker was to undergo surgical intervention. The rationale for the request was not provided. Given the above, the request is not medically necessary.