

Case Number:	CM15-0137075		
Date Assigned:	07/27/2015	Date of Injury:	02/06/2004
Decision Date:	09/18/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	07/15/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 51 year old male, who sustained an industrial injury on 2/6/04. He reported standing behind a truck, the truck rolled forward and threw him to the ground and was pulled by the truck 10/20 feet with his right arm in the door. The injured worker was diagnosed as having left total knee replacement, right shoulder status post arthroscopy, subacromial decompression and acromial joint resection, right shoulder strain-tendinitis, cervical strain, radiculitis right upper extremity, left shoulder strain-impingement syndrome, low back pain with disc bulge and bilateral facet arthrosis, antalgic gait, depression, plantar fasciitis bilaterally and obesity secondary to injuries. Treatment to date has included 4 arthroscopic surgeries of shoulders and knees, interlaminar epidural steroid injection, oral medications including Nortriptyline, naproxen and cyclobenzaprine; physical therapy and activity restrictions. Currently on 5/19/15, the injured worker complains increasing pain in his back and knees since last evaluation as well as pain in both hips. Work status is noted to be permanent and stationary. Physical exam performed on 5/19/15 revealed an antalgic gait, tenderness to palpation of paralumbar musculature, spasms of paralumbar musculature, restricted lumbar range of motion, well healed scars of left knee with diffuse tenderness and exam of right knee revealed crepitus, medial joint line tenderness, lateral joint line tenderness and patellofemoral facet tenderness. The treatment plan included scheduled total knee replacement, refills of cyclobenzaprine 7.5mg, Wellbutrin 150mg and Omeprazole 20mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post operative Home Health Care, 4 wks, unknown frequency: 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: CA MTUS guidelines recommend "home health services for patients who are homebound, on a part time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning and laundry, and personal care given by home health aides like bathing, dressing and using the bathroom when this is the only care needed." In this case, there is no indication the injured worker is homebound; the frequency of visits was unknown as was the type of home health service requested. The request for post-operative home health care is not medically necessary.

Omeprazole 20 mg Qty 60: 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 NSIADs, GI symptoms and cardiovascular risks Page(s): 68-69.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented gastrointestinal distress symptoms, or at risk for gastrointestinal events. Gastrointestinal risk factors include: age >65, history of peptic ulcer, gastrointestinal bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. There is no documentation indicating that this patient had any gastrointestinal symptoms or risk factors. Based on the available information provided for review, the patient has not been maintained on NSAIDs. The medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.

Vascutherm Machine, 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: Knee & Leg - Game Ready accelerated recovery system.

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 (Acute & Chronic) / Continuous-flow cryotherapy / Continuous passive motion (CPM).

Decision rationale: The MTUS / ACOEM did not address the use of continuous flow cryotherapy with compression, therefore other guidelines were consulted. Per the ODG, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage." There is limited information to support active vs. passive cryo units. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. This study concluded that continuous cold therapy devices, compared to simple icing, resulted in much better nighttime pain control and improved quality of life in the early period following routine knee arthroscopy. Two additional RCTs provide support for use after total knee arthroplasty (TKA). Cold compression reduced blood loss by 32% and pain medication intake by 24%. (Levy, 1993) It improved ROM and reduced hospital stay by 21% " However a review of the injured workers medical records do not reveal a clear rationale for the purchase of multiple units that are expected to be used for no more than 21 days in the post operative setting where rental would be more appropriate. Without this information it is not possible to establish medical necessity, therefore the request for Vascutherm Machine, purchase is not medically necessary.

Cyclobenzaprine 7.5 mg Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: According to the reviewed literature, Cyclobenzaprine is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the available records show that the patient has not shown a documented benefit or any functional improvement from prior Cyclobenzaprine use. He has utilized Cyclobenzaprine since at least 3/10/15. Based on the currently available information; the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

CPM (continuous passive motion) device, 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: 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 (ODG) Knee, continuous passive motion (CPM).

Decision rationale: CA MTUS guidelines are silent regarding (CPM), therefore, ODG was consulted. ODG recommends continuous passive motion (CPM) for home 4-10 consecutive days (no more than 21) for total knee arthroplasty. CPM is recommended for home or in hospital use for patients at risk of a stiff knee, based on demonstrated compliance and measured improvements. The request for purchase of CPM machine is not recommended, the request did not indicate the number of days it would be utilized. The request is not medically necessary.

Ice Therapy Machine, 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: 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) Knee, continuous flow cryotherapy.

Decision rationale: CA MTUS guidelines are silent regarding continuous flow cryotherapy, therefore, ODG was consulted. ODG recommends continuous flow cryotherapy for home use for up to 17 days for home following total knee arthroplasty under conditions of low postoperative mobility or inability to comply with rehabilitation exercises. Continuous flow cryotherapy is recommended for home or in hospital use for patients at risk of a stiff knee, based on demonstrated compliance and measured improvements. The request for ice therapy machine purchase is not recommended, the request did not indicate the number of days it would be utilized. The request is not medically necessary.

Home Health Physical Therapy, 4 wks, post operative, unknown frequency: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: CA MTUS guidelines recommend "home health services for patients who are homebound, on a part time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning and laundry, and personal care given by home health aides like bathing, dressing and using the bathroom when this is the only care needed." In this case, there is no indication the injured worker is homebound; the frequency of visits is unknown and there is no clear rationale as to why this has to be in home PT as opposed to center based. Without this information medical necessity is not established. The request for post-operative home health physical therapy is not medically necessary.

