

Case Number:	CM15-0165501		
Date Assigned:	09/03/2015	Date of Injury:	11/05/2009
Decision Date:	10/06/2015	UR Denial Date:	07/21/2015
Priority:	Standard	Application Received:	08/24/2015

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: 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 43-year-old female who sustained a work related injury November 5, 2009. According to a primary treating physician's progress report, dated June 23, 2015, the injured worker presented for a follow-up visit. An MRI of the left knee performed June 3, 2015 (report present in the medical record) revealed severe osteoarthritis, medial compartment, with grade 2-3 changes in the patellofemoral joint and a complete chronic tear of the anterior cruciate ligament (ACL). Objective findings are documented as synovial thickening with decreased range of motion and significant laxity on exam. Diagnosis is documented as ACL tear, degenerative joint, left knee. Treatment plan included discussion of treatment options, included ACL reconstruction to be scheduled, an injection of Depo-Medrol and Xylocaine to the left knee, and at issue, a request for authorization for post- surgical home health care 7 days a week for 8 hours a day for 6 weeks, and a mobility scooter.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health care 7 days a week for 8 hours a day for 6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services, page 52.

Decision rationale: MTUS and Medicare guidelines support home health for patients who are homebound requiring intermittent skilled nursing care or home therapy and do not include homemaker services such as cleaning, laundry, and personal care. The patient does not meet any of the criteria to support this treatment request and medical necessity has not been established. Submitted reports have not adequately addressed the indication or demonstrated the necessity for home health. The patient does not appear homebound as the patient attends office visits independently without person or equipment assist. There is no specific deficient performance issue evident as it is reported the patient has no documented deficiency with the activities of daily living. It is unclear if there is any issue with family support. Reports have unchanged chronic symptoms without clear progressive neurological deficits identified for home therapy. Submitted reports have not demonstrated support per guidelines criteria for treatment request. The Home health care 7 days a week for 8 hours a day for 6 weeks is not medically necessary and appropriate.

Mobility scooter x 1: 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), PMD.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Scooter, page 100.

Decision rationale: Review indicates the patient was authorized for a front wheel walker. Per MTUS Guidelines regarding power mobility devices such as scooters, they are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. There is notation the patient has been utilizing a cane. Submitted reports noted globally intact motor strength in the upper and lower extremity muscles without clear neurological deficits. There is no physical therapy report identifying any ADL limitations or physical conditions requiring a purchase of a motorized scooter nor is there any failed trial of other non-motorized walking aide. The criteria for the power mobility device have not been met from the submitted reports. There is no documented clinical motor or neurological deficits of the upper extremities to contradict the use of the cane as the patient has been sufficiently using as a walking aide as in this case, the walker that was recently authorized. The Mobility scooter x 1 is not medically necessary and appropriate.