

<b>Case Number:</b>	CM15-0082524		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	09/19/2013
<b>Decision Date:</b>	06/03/2015	<b>UR Denial Date:</b>	04/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic 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 57 year old female, who sustained an industrial injury on September 16, 2013. She reported bilateral wrists, right hip, lumbar spine and right knee. The injured worker was diagnosed as having central canal and neural foraminal stenosis of the lumbar spine, right hip pain and hip arthrosis, status post right knee arthroscopy and lumbar disk herniation with right sided radiculopathy. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention of the right knee, conservative care, medications and work restrictions. Currently, the injured worker complains of continued reported bilateral wrists, right hip, lumbar spine and right knee. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on March 27, 2015, revealed continued pain. It was noted she would require a total hip replacement. Post-operative home health care, post-operative cold interferential unit and a platelet rich plasma injection were requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Platelet rich plasma (PRP) injection for Healing of bone graft: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) hip.

**Decision rationale:** CAMTUS/ACOEM is silent on the issue of PRP use with hip arthroplasty. ODG Hip is referenced. Not recommended as studies seem to indicate there is no role for PRP associated with an arthroplasty. The request is therefore not medically necessary.

**Post Op cold therapy unit 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 (ODG), 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) hip.

**Decision rationale:** CA MTUS/ACOEM guidelines are silent on the issue of DME. Per the ODG Knee and Leg section, Durable medical equipment is generally defined as a device that meets Medicare definition. The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. As the request in this case is for purchase, the request is not in keeping with guidelines and is therefore not medically necessary.

**Home health care post surgery:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines medical treatment guidelines Page(s): 51.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 51, Home Health Services are recommended only for medical treatment in patients who are home-bound on a part-time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Home health skilled nursing is recommended for wound care or IV antibiotic administration. The requested surgery typically does not require home infusion or wound care and therefore does not meet guidelines for home health care. Therefore the request is not medically necessary.