

Case Number:	CM14-0115032		
Date Assigned:	09/05/2014	Date of Injury:	01/30/2000
Decision Date:	10/08/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/23/2014

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. The expert reviewer is Board Certified in Internal Medicine, has a subspecialty in Pulmonary Diseases and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 reported injury on 01/30/2000 caused by an unspecified mechanism. Treatment history included MRI studies, EMG studies, CT scan studies, trigger point injections and medications. The injured worker was evaluated on 06/04/2014 and it was documented that the injured worker's back pain has worsened since her right knee replacement surgery. The provider requested a cervical retraction unit, inversion table, and orthopedic mattress. She stated her knee was showing some improvement, but she was complaining of increased neck and back pain, especially from awkward ambulation. The injured worker continues to suffer from right knee pain and decreased range of motion. She can only flex the knee to 90 degrees. She indicated that she had a followup appointment with an orthopedic doctor. The provider noted she went weekly to [REDACTED] for trigger point injections. Physical examination of the knee revealed large 6 inch incision over the right knee. She was unable to deep knee bend. There was patellar joint pain, medial joint line pain, and lateral joint line pain on the right and left. Patellofemoral was positive on right and left. There was tenderness to palpation in the cervical spine region, especially over the C6 region bilaterally with 1 inch large trigger point. Range of motion of the cervical spine was reduced in all directions by 10 degrees with pain on any ranges. Positive foraminal compression test and positive shoulder decompression test. Deep tendon reflexes of upper extremities at triceps and biceps are reduced to +1. Right shoulder had limited range of motion with well healed portals. There was tenderness and swelling over the region. Diagnoses included postop right shoulder, status post left knee arthroscopic surgery, major depression currently being treated with medications, lumbar spine HNP with radiculopathy, cervical spine HNP with radiculopathy, osteoarthritis of the left knee, total knee replacement of the right knee, allergic reaction to the

right knee implant, dental decay, and nausea and vertigo. The Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Elevator: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee & Leg, Durable Medical Equipment.

Decision rationale: c)My rationale for why the requested treatment/service is or is not medically necessary: The requested is not medically necessary. According to the Official Disability Guidelines (ODG) state that Durable medical equipment the home. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. Certain DME toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. Many assistive devices, such as electric garage door openers, microwave ovens, and golf carts, were designed for the fully mobile, independent adult, and Medicare does not cover most of these items. The documents submitted failed to indicate the rationale why the injured worker is requiring a home elevator. As such, the request for a home elevator is not medically necessary.