MAXIMUS Federal Services

Case Number:	CM15-0008880		
Date Assigned:	01/26/2015	Date of Injury:	06/21/2014
Decision Date:	03/17/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/15/2015

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: Illinois, California, Texas
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:

This 81 year old male was injured in an industrial accident involving a fall on 6/21/14. He currently complains of constant left knee pain. Medications are Vicodin and ibuprofen. Treatments have included medication and cortisone injection into left knee which offered some relief. Diagnosis was knee pain, internal derangement. Diagnostics included left knee radiographs (8/10/14), total knee arhroplasty right knee, abnormal MRI left knee (8/13/14). On 12/20/14 Utilization Review non-certified requests for home health care 2 X a week for 3 weeks citing MTUS. Post-operative Physical Therapy 3 X a week X 4 weeks was non-certified citing MTUS Post-surgical Treatment Guidelines: Knee. Cold Therapy Unit with Pad was non-certified citing ODG Knee & Leg. The associated request for total knee arthroplasty was found to be not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Cold therapy unit with pad: 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 and Leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and Leg; Continuous flow cryotherapy

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after knee surgery, for up to 7 days, including home use. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines and there is no documentation that the associated surgical procedure has been found medically necessary. Therefore, this request for cold therapy unit with pad is not medically necessary.

Post-op physical therapy 3 x 4 to the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for knee arthroplasty suggest a general course of 24 post-operative visits over 10 weeks during the 4-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. This request is consistent with guidelines for physical therapy treatment following total knee arthroplasty, there is no documentation that the associated surgical procedure has been found medically necessary. Therefore, this request for post-op physical therapy 3x4 to the left knee is not medically necessary.

Associated surgical service: Home health care 2 x 3: 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 Home health services Page(s): 51.

Decision rationale: The California MTUS recommends home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis. 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. Guideline criteria have not been met. There is no clear documentation as the type of home health services being recommended for this patient to establish medical necessity. There is no documentation that the associated surgical procedure has been found medically necessary. Therefore, this request for home health care 2x3 is not medically necessary.