

Case Number:	CM15-0019416		
Date Assigned:	02/09/2015	Date of Injury:	10/07/2009
Decision Date:	04/14/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/03/2015

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: Minnesota, Florida
 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 51-year-old man sustained an industrial injury on 10/7/2009. The mechanism of injury is not detailed. Current diagnoses include left knee pain, joint pain in ankle and foot, sprain of shoulder and upper arm, osteoarthritis of knee, memory impairment, and opioid dependence. Treatment has included oral medications and multiple surgical interventions. Physician notes dated 1/15/2015 show the worker states the knee feels the same, including palpitations, light headed, muscle weakness, joint pain, back pain, dizziness, and headaches. He developed an infection in his total knee and the implant was removed and an antibiotic impregnated cement spacer was inserted. The CRP remained elevated despite treatment and so a new antibiotic spacer is planned to eradicate the infection. This was approved by utilization review. Multiple requests were submitted for authorization, including those in dispute. On 1/26/2015, Utilization Review evaluated prescriptions for power wheel chair and home health care, three times per week for two weeks, that was submitted on 2/3/2015. The UR physician noted that there is no documentation the worker cannot manage a manual wheelchair or walker. Regarding the home health service, a registered nurse evaluation is suggested to be completed to determine the necessity of care as well as frequency and duration. The MTUS, ACOEM Guidelines, (or ODG) was cited. The requests were denied and subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Power Wheelchair 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), Knee & Leg (updated 10/27/14), Wheelchair.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices Page(s): 99.

Decision rationale: The guidelines do not recommend power mobility devices if there is sufficient strength in the upper extremities to propel a manual wheelchair. Early exercises should be encouraged and based upon the documentation provided, a power wheelchair is not essential to care. As such, the request for a power wheelchair is not supported and the medical necessity is not substantiated.

Post-Operative Home Health 3 Times a week for 2 weeks: 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), Knee & Leg (updated 10/27/14), Home Health Services.

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

Decision rationale: Home health services are recommended only for otherwise recommended medical treatment for patients who are homebound. The documentation provided does not indicate that IW will be homebound after the antibiotic spacer exchange. Utilization Review recommended a Registered Nurse evaluation for the need of home health services which is appropriate. The request as stated is not supported by documentation of the necessity of home medical services. As such, the medical necessity of the request for post-operative home health 3 times a week for 2 weeks is not substantiated.