

Case Number:	CM15-0110497		
Date Assigned:	06/17/2015	Date of Injury:	08/03/2011
Decision Date:	07/22/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/08/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 60 year old female sustained an industrial injury to the neck, back, left shoulder and bilateral knees on 8/3/11. Previous treatment included cervical fusion, epidural steroid injections, physical therapy, cane, knee brace, hot and cold packs and medications. A letter dated 4/15/15 indicated that the injured worker was scheduled to undergo right total knee arthroplasty on 4/15/15. Documentation did not disclose a postoperative physical assessment or operative report. In a durable medical equipment form dated 3/16/15, the physician noted that the injured worker could go to [REDACTED] rehabilitation. On 3/26/15, a request for authorization was submitted for a knee continuous passive motion machine, Kodiak cold therapy, a 3 in 1 commode and a front wheel walker.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative physical therapy, 2-3 times weekly for the right knee, QTY: 18: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient had physical therapy after her right knee arthroplasty. There is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the additional 18 PT sessions requested, which exceed the MTUS and ODG guidelines. Medical necessity for the additional PT visits requested has not been established. The requested services are not medically necessary.

Post-operative occupational therapy, 2-3 times weekly for the right knee, QTY: 12: Upheld

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

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

Decision rationale: According to the ODG, physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy (OT), Chiropractic, and MD/DO). In this case, there is no documentation of the specific modalities needed in occupational therapy that could not be done in a home exercise program. Medical necessity for the requested 12 sessions of post-operative OT has not established. The requested services are not medically necessary.

Wheelchair rental, QTY: 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), Knee & Leg, Wheelchair.

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

Decision rationale: According to the ODG, a manual wheelchair is recommended if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. Reclining back option recommended if the patient has a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day. Elevating leg rest option recommended if the patient has a cast, brace or musculoskeletal condition, which prevents 90-degree flexion of the knee, or has

significant edema of the lower extremities. Adjustable height armrest option recommended if the patient has a need for arm height different than that available using non-adjustable arms. A lightweight wheelchair is recommended if the patient cannot adequately self-propel (without being pushed) in a standard weight manual wheelchair, and the patient would be able to self-propel in the lightweight wheelchair. In this case, the patient is status post right total knee replacement. There is no evidence that this patient has an inability to move within her residence. Medical necessity has not been established. Therefore, the requested wheelchair rental is not medically necessary.

Front Wheeled Walker, QTY: 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), walking aids (canes, crutches, braces, orthoses & walkers).

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

Decision rationale: According to the ODG. walking aides are recommended based on disability, pain, and age-related impairments. In this case, the patient is being treated for chronic neck pain, back pain, left shoulder and bilateral knee pain. She is status post right total knee arthroplasty. There is no evidence that this patient has an inability to move within her residence. There is no specific indication for a walking aid. Therefore, the requested front-wheeled walker is not medically necessary.