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| Case Number: | CM15-0129458 | | |
| Date Assigned: | 07/16/2015 | Date of Injury: | 08/30/1999 |
| Decision Date: | 08/11/2015 | UR Denial Date: | 06/12/2015 |
| Priority: | Standard | Application Received: | 07/06/2015 |

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 Jersey, Alabama,

California

Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 58 year old male with an industrial injury dated 08/30/1999. The injured worker's diagnoses include patellar subluxation and status post right total knee replacement. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In a progress note dated 06/04/2015, the injured worker presented for post-operative visit for his right knee patellar realignment performed on 05/21/2015. Objective findings revealed extensive ecchymosis, moderate swelling, effusion, and healing scar without infection. The treating physician reported slow progress with rehabilitation, somewhat compromised by his living situation. The treating physician prescribed medical transportation (additional days) QTY: 18, physical therapy, right knee QTY: 18 and electric scooter (indefinite use) QTY: 1, now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medical transportation (additional days) QTY: 18: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation California dept of health care services criteria manual chapter 12.1, criteria for medical transportation and related services.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Transportation (to & from appointments) <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, Transportation (to & from appointments) "Recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. (CMS, 2009) Note: This reference applies to patients with disabilities preventing them from self-transport who are age 55 or older and need a nursing home level of care. Transportation in other cases should be agreed upon by the payer, provider and patient, as there is limited scientific evidence to direct practice." There is no documentation that the patient is unable to use public transportation safely and independently to attend his medical appointments. Therefore, the request for Medical transportation (additional days) QTY: 18 is not medically necessary.

Physical therapy, right knee QTY: 18: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is "recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment." (Fritz, 2007) In this case, the frequency of the treatment should be reduced from 18 to 3 or less sessions. More sessions will be considered when functional and objective improvement are documented. There is no documentation that the patient cannot perform home exercise. Therefore, the request for 18 physical therapy sessions for the right knee is not medically necessary.

Electric scooter (indefinite use) QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PMDs Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices Page(s): 97.

Decision rationale: According to MTUS guidelines, "Power mobility devices are not recommended. The functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." There is no documentation that the patient does not have sufficient muscle strength to use a manual wheelchair. Therefore, the requested for Electric scooter (indefinite use) is not medically necessary.