

Case Number:	CM15-0176033		
Date Assigned:	09/17/2015	Date of Injury:	10/27/2011
Decision Date:	10/21/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/08/2015

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: California, Indiana, New York
 Certification(s)/Specialty: Internal 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 50-year-old female, with a reported date of injury of 10-27-2011. The diagnoses include moderate to severe osteoarthropathy of the right knee, status post remote right knee arthroscopy, and right shoulder chronic impingement syndrome, supraspinatus tear, and SLAP (superior labral anterior posterior) lesion. Treatments and evaluation to date have included Hydrocodone, Tramadol, arthroscopic right knee surgery in 2013, Vicodin, Naprosyn, and a muscle relaxer. The diagnostic studies to date have included an MRI of the right shoulder on 04-23-2014 which showed tendinopathy with mild bursal sided partial tearing of the rotator cuff and concerns for subtle tearing of the labrum; electrodiagnostic studies of the upper extremities on 12-16-2011 with normal findings; and an MRI of the right knee on 10-16-2014 which showed mild prepatellar (knee cap) bursal swelling with mild patellar tendinopathy. According to the agreed medical evaluation dated 06-29-2015, the injured worker underwent an electrodiagnostic studies times two. The follow-up consultation dated 08-21-2015 indicates that the injured worker had increasing right knee pain, which was rated 8 out of 10; left knee pain, rated 5 out of 10; worsening right shoulder pain, rated 7 out of 10; low back pain with right greater than left lower extremity symptoms, rated 6 out of 10; thoracic pain, rated 5 out of 10; and right forearm and elbow pain, which was rated 5 out of 10. It was noted that a right total knee arthroplasty has been requested. The objective findings include tenderness of the right knee; right knee range of motion 0-90 degrees; tenderness of the right shoulder anterior aspect and at the acromioclavicular joint; right shoulder flexion at 90 degrees; right shoulder abduction at 80 degrees; right shoulder external rotation at 40 degrees; right shoulder internal rotation at 35

degrees; swelling of the right shoulder; and atrophy of the right deltoid musculature. The treatment plan included a right total knee arthroplasty and associated services. The injured worker's work status was noted as temporarily totally disabled for four weeks. The treating physician requested home health physical therapy three times a week for two weeks. On 08-27-2015, Utilization Review (UR) non-certified the request for home health physical therapy three times a week for two weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health physical therapy 3 times a week for 2 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services, Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Home health services, Pain section, Physical therapy.

Decision rationale: Pursuant to the Official Disability Guidelines, home health physical therapy three times per week times two weeks is not medically necessary. Home health services are recommended on a short-term basis following major surgical procedures or inpatient hospitalization or to provide longer term nursing care and supportive services for those whose condition is such that they would otherwise require inpatient care. Home healthcare is the provision of medical and other health care services to the injured party at their place of residence. These services include both medical and non-medical services for patients who are the teams. They waited a minute confined to the home and who require: skilled care by a lawyer who is right for me in his seat licensed medical professional; and or personal care services for health- related tasks such as bowel and bladder care feeding, bathing etc. Domestic services such as shopping, cleaning and laundry that the individual is no longer capable of performing due to illness or injury may be medically necessary. Justification for medical necessity of home health services required documentation of the medical condition including objective deficits; expected kinds of services that with an estimate of the duration and frequency; the level of expertise and professional qualification or licensure; etc. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are moderate to severe osteoarthropathy is right knee; status post remote right knee arthroscopy; right shoulder chronic impingement syndrome, 25% tear supraspinatus, SLAP tear; right lumbar radiculopathy; calcific tendinitis right shoulder with adhesive capsulitis. Date of injury is October 27, 2011. Request for authorization is August 20, 2015. According to a July 31, 2015 progress note, the injured worker's subjective complaints include right knee pain, right shoulder pain and low back pain. Objectively, there is tenderness in the right knee. There is tenderness of the lumbar spine with decreased range of motion. There is decreased range of motion of the right shoulder. A right total knee arthroplasty was approved. There is no

documentation in the medical record the injured worker will be homebound in the postsurgical phase of the right total knee arthroplasty. The request for homebound physical therapy appears in the request for authorization only. There is no clinical indication or rationale (based on clinical documentation) for homebound physical therapy in the progress note dated July 31, 2015. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation indicating the injured worker will be homebound in the post operative phase of the total knee arthroplasty and no discussion or clinical rationale for home-based physical therapy in the medical record progress note dated July 31, 2015, home health physical therapy three times per week times two weeks is not medically necessary.