

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

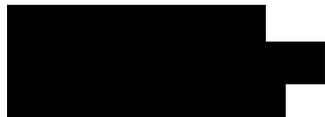
Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 12/17/2013



Employee:	
Claim Number:	
Date of UR Decision:	7/30/2013
Date of Injury:	3/2/2010
IMR Application Received:	8/23/2013
MAXIMUS Case Number:	CM13-0016028

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Front-Wheel Walker for purchase is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **3 in 1 Commode for purchase is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Crutches for purchase is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Cold Intermittent Pneumatic Compression with DVT Prophylaxie for 3 weeks rental is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Home CPM machine for 1-3 weeks rental is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/23/2013 disputing the Utilization Review Denial dated 7/30/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Front-Wheel Walker for purchase is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **3 in 1 Commode for purchase is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Crutches for purchase is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Cold Intermittent Pneumatic Compression with DVT Prophylaxie for 3 weeks rental is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Home CPM machine for 1-3 weeks rental is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation , has a subspecialty in Interventional Spine and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

This is a 58 year old man with a 3/2/10 injury. He slipped and twisted his left knee and hyperextended his right knee. He has history of right THR, and right knee medial and lateral meniscectomy, and diabetes. X-ray of the left knee are reported to show tricompartmental OA. The patient is disputing the 7/30/13 UR decision that is denying the front-wheel walker purchase, 3 in 1 comode purchase, Crutches, a cold intermittent pneumatic compression with DVT prophylaxis rental for 3-weeks, and a home CPM machine for 1-3 weeks rental. He was apparently awaiting authorization for a left knee TKA and the DME was for post-operative care. UR stated the surgery was not necessary, so the DME was not necessary.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:



1) Regarding the request for Front-Wheel Walker for purchase:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the CA MTUS 2009; 9792.23.6 Knee Complaints, ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2008, pg1017, which is part of the MTUS, and the Official Disability Guidelines, (ODG), Section on Knee and Leg, (Updated 6/7/2013), which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, (Online), Knee Chapter, Walking Aids, which is not part of the MTUS.

Rationale for the Decision:

The ODG Guidelines reference that walking aids canes, crutches, braces, orthoses, & walkers are recommended and that almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Frames or wheeled walkers are preferable for patients with bilateral disease. In this case, the employee has a history of right hip replacement and is also status post right knee meniscal surgery. The employee also has tricompartmental osteoarthritis in the left knee, for which he is awaiting a total knee replacement (TKA) and this walker was recommended for post-left knee TKA use. This appears to be in accordance with ODG criteria with or without the left knee TKA. **The request for a Front Wheel Walker for purchase is medically necessary and appropriate.**

2) Regarding the request for 3 in 1 Commode for purchase :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, (ODG), Section on Knee and Leg which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, (ODG), Knee Chapter for DME, which is not part of the MTUS.

Rationale for the Decision:

Since the primary procedure is not medically necessary, none of the associated services are medically necessary. From the information provided, there was no mention to confirm that the employee underwent the left knee TKA. If the employee had the left knee TKA, this item would appear medically necessary. Without the left knee TKA, the necessity of the DME is not apparent. It would be reasonable to reconsider this request for this DME if there is evidence that the surgery has been approved or scheduled. **The request for a 3 in 1 commode for purchase is not medically necessary and appropriate.**

3) Regarding the request for Crutches for purchase:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the CA MTUS 2009; 9792.23.6 Knee Complaints, ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2008, pg1017, which is part of the MTUS, and the Official Disability Guidelines, (ODG), Section on Knee and Leg, (Updated 6/7/2013), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Knee Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13) pg 338, Table 13-3, which is part of the MTUS, and the Official Disability Guidelines, (ODG), Knee Chapter on Walking Aids, which is not part of the MTUS.

Rationale for the Decision:

Since the primary procedure is not medically necessary, none of the associated services are medically necessary. From the information provided, there was no mention to confirm that the employee underwent the left knee TKA. If the employee had the left knee TKA, this item would appear medically necessary. Without the left knee TKA, the necessity of the DME is not apparent. It would be reasonable to reconsider this request for this DME if there is evidence that the surgery has been approved or scheduled. **The request for Crutches is not medically necessary and appropriate.**

4) Regarding the request for Cold Intermittent Pneumatic Compression with DVT Prophylaxie for 3 weeks rental:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the CA MTUS 2009; 9792.23.6 Knee Complaints, ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2008, pgs 1015-1017, which is part of the MTUS, and the Official Disability Guidelines, (ODG), Section on Knee and Leg, Continuous Flow Cryotherapy, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, (ODG), Knee Chapter on Continuous Flow Cryotherapy, which is not part of the MTUS.

Rationale for the Decision:

Since the primary procedure is not medically necessary, none of the associated services are medically necessary. From the information provided, there was no mention to confirm that the employee underwent the left knee TKA. If the employee had the left knee TKA, this item would appear medically necessary. Without the left knee TKA, the necessity of the DME is not apparent. It would be reasonable to reconsider this request for this DME if there is evidence that the surgery has been approved or scheduled. **The request for Cold Intermittent Pneumatic Compression with DVT Prophylaxie for 3 weeks rental is not medically necessary and appropriate.**

5) Regarding the request for Home CPM machine for 1-3 weeks rental :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, (ODG), Section on Knee and Leg, Continuous Passive Motion, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, (ODG), Knee Chapter on Continuous Passive Motion, (CPM), which is not part of the MTUS.

Rationale for the Decision:

ODG guidelines have criteria for use of the CPM only after a surgical procedure. Since the primary procedure is not medically necessary, none of the associated services are medically necessary. From the information provided, there was no mention to confirm that the employee underwent the left knee TKA. If the employee had the left knee TKA, this item would appear medically necessary. Without the left knee TKA, the necessity of the DME is not apparent. It would be reasonable to reconsider this request for this DME if there is evidence that the

surgery has been approved or scheduled. **The request for Home CPM machine for 1-3 weeks rental is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/pas

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.