

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/28/2013

[Redacted]

[Redacted]

Employee: [Redacted]
Claim Number: [Redacted]
Date of UR Decision: 7/1/2013
Date of Injury: 7/29/2007
IMR Application Received: 7/22/2013
MAXIMUS Case Number: CM13-0002529

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 long-reach pick-up gripper (purchase) **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 raised toilet seat (purchase) **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 6 sessions of post-operative home physical therapy **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for 12 sessions of post-operative out-patient physical therapy **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for 1 long shoe horn (purchase) **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for 1 home health nurse evaluation **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for 7 days of possible use of transitional care **is not medically necessary and appropriate.**

- 8) MAXIMUS Federal Services, Inc. has determined the request for 12 tablets of xarelto 10 mg **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for 1 month rental of continuous passive motion machine **is not medically necessary and appropriate.**
- 10)MAXIMUS Federal Services, Inc. has determined the request for 1 cane **is not medically necessary and appropriate.**
- 11)MAXIMUS Federal Services, Inc. has determined the request for 1 month rental of hot and cold therapy unit **is not medically necessary and appropriate.**
- 12)MAXIMUS Federal Services, Inc. has determined the request for 1 walker (purchase) **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. 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 1 long-reach pick-up gripper (purchase) **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 raised toilet seat (purchase) **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 6 sessions of post-operative home physical therapy **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for 12 sessions of post-operative out-patient physical therapy **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for 1 long shoe horn (purchase) **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for 1 home health nurse evaluation **is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for 7 days of possible use of transitional care **is not medically necessary and appropriate.**
- 8) MAXIMUS Federal Services, Inc. has determined the request for 12 tablets of xarelto 10 mg **is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for 1 month rental of continuous passive motion machine **is not medically necessary and appropriate.**
- 10) MAXIMUS Federal Services, Inc. has determined the request for 1 cane **is not medically necessary and appropriate.**
- 11) MAXIMUS Federal Services, Inc. has determined the request for 1 month rental of hot and cold therapy unit **is not medically necessary and appropriate.**
- 12) MAXIMUS Federal Services, Inc. has determined the request for 1 walker (purchase) **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 Orthopedic Surgery 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:

The patient is a 41-year-old female. Official MRI of the lumbar spine was conducted on 12/07/2011 by an unknown author that revealed at T12-L1 there was intervertebral disc space, spinal canal, neural foramina, and facet joints to be normal. At L1-2 there was mild left central stenosis due to approximately 3 mm left posterior protrusion of disc. The L1 nerves exit without compression. Facet joints were normal. The intervertebral disc space was mildly narrowed with partial diminution of disc signal. At L2-3 the intervertebral disc space, spinal canal, neural foramina, and facet joints were normal. At L3-4 there was a right lateral recess stenosis due to approximately 2 mm to 3 mm right posterolateral disc protrusion and mild right facet hypertrophy. There was no significant central stenosis. Although right lateral component of disc protrusion extends into inferior aspect of right neural foramina, the right L3 nerve root exits without compression. Left neural foramen was normal in caliber. The intervertebral disc space was normal in height with partial diminution of disc signal. At L4-5 there was mild bilateral lateral recess stenosis present due to approximately a 2 mm to 3 mm disc bulge and mild bilateral facet hypertrophy. There was no significant central stenosis. The L4 nerves exit without compression. The intervertebral disc space was normal in height with partial diminution of disc signal. At L5-S1 there was right lateral recess stenosis with compression of origin of descending right S1 nerve due to approximately a 3 mm to 4 mm right posterolateral disc protrusion and mild right facet hypertrophy. In clinical note dated 06/18/2013 by [REDACTED], MD, it states the patient was seen for a follow-up evaluation. The patient was seen approximately 4 weeks ago, at which time she had undergone a lumbar epidural injection along with a left L5 nerve root block for treatment of low back and left leg pain secondary to L5-S1 disc protrusion. The patient reported minimal, if any, improvement. The patient did continue to have severe pain in the back and down the left leg. The patient did have reports of an L5-S1 disc protrusion with bilateral S1 radiculopathy. The provider stated that most likely the patient would at least need consideration for corrective surgery. On 07/02/2013, an appeals report was issued by [REDACTED], MD. The provider stated that due to failure to improve with conservative treatment, the patient was referred for an orthopedic joint consultation on 10/12/2012. The patient had already undergone at least 7 to 9 cortisone injections of multiple positions and had undergone a trial of Synvisc by Dr. [REDACTED]. The patient had undergone multiple arthroscopic procedures to the left knee, with the most recent being by Dr. [REDACTED]. The patient failed to improve with the cortisone injections, approximately 9, Synvisc injection, and 2 arthroscopic procedures including chondroplasty. The patient's treating physician considered the patient a candidate for total joint arthroplasty. The patient was ultimately recommended by undergo left total knee arthroplasty. The patient received a denial on 07/01/2013, citing multiple reasons why the procedure should not be done. The patient was noted to have undergone physical therapy, 2 prior procedures, and 9 cortisone injections, as well as a

trial of Synvisc and was still symptomatic. The provider stated since he had recommended a total replacement, it did indicate that he had already evaluated the patient's films and had made the best choice and did not need a non-orthopedic physician that could not interpret a film for joint reconstruction. The patient would additionally need crutches to be used on a daily basis. The patient had difficulty going up and down stairs. The patient had difficulty getting in and out of a car. The patient had difficulty getting in and out of a car. The patient did need help to get her shoes and socks on and off. The patient's pain interfered with sleep. The patient was noted to have range of motion 2 degrees through 137 degrees, which was decreased range of motion in a 41-year-old female.

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:

- Application for Independent Medical Review (received 07/22/2013)
- Utilization Review Determination from [REDACTED] (dated 07/01/2013)
- Employee medical records from [REDACTED] (dated 08/03/2013)
- Employee medical records from Employee Representative (08/05/2013)
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for 1 long-reach pick-up gripper (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), Knee & Leg Chapter, Home Health Services section and Walking Aids section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (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 ODG, Knee & Leg Chapter, Durable Medical Equipment section.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/2013. There was no current postoperative condition present to warrant postoperative durable medical equipment. The ODG recommends durable medical equipment if it meets Medicare's definition. There is no indication that the employee has a postoperative condition requiring the use of a pick-up gripper purchase. The request for 1 long-reach pick-up gripper **is not medically necessary or appropriate.**

2) Regarding the request for 1 raised toilet seat (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), Knee & Leg Chapter, Home Health Services section and Walking Aids section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (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 ODG, Knee & Leg Chapter, Durable Medical Equipment section.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/2013. There was no current postoperative condition present to warrant postoperative durable medical equipment. The ODG recommends durable medical equipment if it meets Medicare's definition. There is no indication that the employee has a postoperative condition requiring the use of a pick-up gripper purchase. The request for 1 raised toilet seat **is not medically necessary or appropriate.**

3) Regarding the request for 6 sessions of post-operative home physical therapy:

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 Postsurgical Treatment Guidelines, Arthroplasty section, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer relied on the Postsurgical Treatment Guidelines, page 24, and Chronic Pain Medical Treatment Guidelines, page 51, which are part of the MTUS.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/13. The request was denied citing there was no current postoperative condition present to warrant home postoperative physical therapy. The MTUS Postsurgical Treatment Guidelines do recommend postoperative physical therapy. For arthroplasty, 24 visits over 10 weeks are recommended. However, there is no indication that the employee has a current postoperative condition that would warrant the requested therapy. There is no indication that the employee would be homebound on a part-time or "intermittent" basis requiring as home postoperative physical therapy. The request for 6 sessions of post-operative home physical therapy **is not medically necessary or appropriate.**

4) Regarding the request for 12 sessions of post-operative out-patient physical therapy:

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 Postsurgical Treatment Guidelines, Arthroplasty section, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/13. The request was denied citing there was no current postoperative condition present to warrant postoperative physical therapy. The MTUS Postsurgical Treatment Guidelines do recommend postoperative physical therapy. For arthroplasty, 24 visits over 10 weeks are recommended. However, there is no indication that the employee has a current postoperative condition that would warrant the requested therapy. The request for 12 sessions of post-operative out-patient physical therapy **is not medically necessary or appropriate.**

5) Regarding the request for 1 long shoe horn (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), Knee & Leg Chapter, Walking Aids section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (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, Knee and Leg Chapter, Online Version, Durable medical equipment (DME).

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/13. There was no current postoperative condition present to warrant postoperative durable medical equipment. The ODG recommends durable medical equipment if it meets Medicare's definition. In agreement with a prior determination, there is no indication that the employee has a postoperative condition requiring the use of a long shoe horn purchase. The request for a long shoe horn purchase **is not medically necessary or appropriate.**

6) Regarding the request for 1 home health nurse evaluation:

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), Knee & Leg Chapter, Walking Aids section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, page 51, Home Health Services section, which is part of the MTUS.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/13. There was no current postoperative condition present to warrant a home health evaluation. The MTUS Chronic Pain Guidelines recommend home health services for patients that are otherwise homebound on a part-time or “intermittent” basis for generally up to no more than 35 hours per week. Medical treatment does not include homemaker services. The request for 1 home health nurse evaluation **is not medically necessary or appropriate.**

7) Regarding the request for 7 days of possible use of transitional care:

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), Knee & Leg Chapter, Walking Aids section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (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 ODG, Knee and Leg Chapter, Skilled Nursing Facility section, which is not part of the MTUS.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/13. There was no current postoperative condition present to warrant postoperative condition present to warrant the necessity of 7 days of transitional care. The ODG states skilled nursing facility care is recommended for patients who have been hospitalized for at least three days following major surgery such as knee replacement. The request for 7 days of possible use of transitional care **is not medically necessary or appropriate.**

8) Regarding the request for 12 tablets of xarelto 10 mg:

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), Knee & Leg Chapter, Rivaroxaben (Xarelto) section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (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 guidelines used by the Claims Administrator.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/13. There was no current postoperative condition present to warrant the requested medication to be used post operatively. The ODG states Xarelto is recommended as an anticoagulant treatment option for patients with venous thromboembolism of the leg. The medication is given for prevention of venous thromboembolism after a total knee arthroplasty. There is no indication that the employee has undergone or has been authorized to undergo the requested procedure. The request for 12 tablets of Xarelto 10mg **is not medically necessary or appropriate.**

9) Regarding the request for 1 month rental of continuous passive motion machine:

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), Knee & Leg Chapter, Continuous Passive Motion section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (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 found the guidelines used by the Claims Administrator.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/13. There was no current postoperative condition present to warrant postoperative durable medical equipment. The ODG recommends continuous passive motion for in hospital use or for home use in patients at risk of a stiff knee, based on demonstrated compliance and measured improvement, but the beneficial effects over regular physical therapy may be small. Routine home use of CPM has minimal benefit. There is no indication that the employee has a postoperative status or has been authorized to undergo the left total knee arthroplasty. The request for 1 month rental of continuous passive motion machine **is not medically necessary or appropriate.**

10) Regarding the request for 1 cane:

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), Knee & Leg Chapter, Walking Aids section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (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 guidelines used by the Claims Administrator.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/13. There was no current postoperative condition present to warrant postoperative durable medical equipment. The ODG recommends durable medical equipment if it meets Medicare's definition. There is no indication that the employee has a postoperative condition requiring the use of a cane. The request for 1 cane **is not medically necessary or appropriate.**

11) Regarding the request for 1 month rental of hot and cold therapy unit:

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), Knee & Leg Chapter, Continuous-Flow Cryotherapy section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (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 guidelines used by the Claims Administrator.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/13. There was no current postoperative condition present to warrant home postoperative physical therapy. The ODG states continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Medical records submitted for review do not indicate that the employee has been authorized to undergo the left knee arthroplasty. The request for 1 month rental of hot and cold therapy unit 6 **is not medically necessary or appropriate.**

12) Regarding the request for 1 walker (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), Knee & Leg Chapter, Walking Aids section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (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 guidelines used by the Claims Administrator.

Rationale for the Decision:

Records submitted for review stated the employee had been recommended to undergo left total knee replacement as documented in an appeals report dated 7/02/13. There was no current postoperative condition present to warrant postoperative durable medical equipment. The ODG recommends durable medical equipment if it meets Medicare's definition. There is no indication that the employee has a postoperative condition requiring the use of a walker purchase. The request for 1 walker **is not medically necessary or 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,

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

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

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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.