

<b>Case Number:</b>	CM14-0177940		
<b>Date Assigned:</b>	10/31/2014	<b>Date of Injury:</b>	11/19/2012
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	09/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Minnesota. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 66 year old male with advanced osteoarthritis of the right knee. The date of injury is 11/19/2012. He complains of knee pain, and has a varus deformity and difficulty walking. He has failed conservative treatment. The request for a total knee arthroplasty has been certified. The disputed issues pertain to post-operative use of a 3-1 commode, unspecified duration of continuous passive motion machine rental, 30 day cold therapy machine rental, and 3 x 4 in-home physical therapy. UR non-certified the commode, modified the CPM machine rental to 21 days, modified the cold therapy rental to 7 days, and modified the in-home physical therapy request to 3 x 2 followed by out-patient physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: 3-1 Commode:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Knee, Topic: Durable Medical equipment, bedside commode

**Decision rationale:** The California MTUS does not address this issue. The ODG guidelines indicate that most bathroom and toilet supplies do not serve a medical purpose but are primarily used for convenience at home. Commodes are necessary if the patient is not ambulatory and is room confined. The documentation indicates that in-patient stay for 7-10 days at a rehabilitation facility has been certified. A front wheeled walker is also certified. Therefore assistance with ambulation and toilet needs will be provided and the request for a 3 in 1 commode is not medically necessary.

**Associated surgical service: CPM Machine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Worker's Compensation Knee & Leg Procedure Summary (last updated 08/25/2014), Criteria for the use of Continuous Passive Motion Devices

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Knee, Topic: Continuous Passive Motion.

**Decision rationale:** The California MTUS does not address the duration of continuous passive motion after a total knee arthroplasty. The ODG guidelines recommend the use of CPM for 4-10 days after a total knee arthroplasty but not more than 21 days. UR has certified rental of a CPM machine for 21 days. The request for CPM machine as stated does not specify the length of use and is not medically necessary beyond the 21 days certified by UR. The request is not medically necessary.

**Associated surgical service: Cold Therapy unit for 30 days rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Worker's Compensation, Knee & Leg Procedure Summary (last updated 08/25/2014), Continuous- Flow Cryotherapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Knee, Topic: Continuous flow cryotherapy.

**Decision rationale:** California MTUS does not address the issue. ODG guidelines recommend continuous flow cryotherapy as an option for 7 days after a total knee arthroplasty. It reduces swelling, inflammation, and pain and reduces the need for narcotics for pain control. UR has certified the rental for 7 days which is appropriate and medically necessary per guidelines. However, the medical necessity of the requested 30 day rental is not established.

**Associated surgical service: In Home Physical Therapy 3 times per week for 4 weeks:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24,10,11.

**Decision rationale:** The Post-surgical treatment guidelines recommend an initial course of therapy of 12 visits for a total knee arthroplasty. The post-surgical treatment is 24 visits over 10 weeks. The post-surgical physical medicine treatment period is 4 months. The guidelines do not address in-home physical therapy. However, the UR approved in-home physical therapy 3 times a week for two weeks. At that point the worker should be mobile enough to attend out-patient physical therapy and use the equipment in the physical therapy department necessary for achieving optimal results with the therapy program. The request for in-home physical therapy 3 times per week for 4 weeks is not supported by guidelines and as such is not medically necessary.