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| <b>Case Number:</b>   | CM14-0178836 |                              |            |
| <b>Date Assigned:</b> | 11/03/2014   | <b>Date of Injury:</b>       | 08/22/2008 |
| <b>Decision Date:</b> | 12/08/2014   | <b>UR Denial Date:</b>       | 09/29/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/28/2014 |

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 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 62 year-old male with a date of injury of August 22, 2008. The patient's industrially related diagnoses include traumatic bilateral knee osteoarthritis, status post total right knee arthroscopy dated on 7/10/2013, and end stage osteoarthritis of the left knee. The disputed issues are requests for Continuous Passive Motion, 30-day rental, purchase of Continuous Passive Motion Pad, Thermacure Unit, 30-day rental, and Thermacare pad purchase. A utilization review determination on 9/29/2014 had non-certified these requests. The stated rationale for the denial was: "The review of the clinical guidelines does not support the use of these modalities over conventional therapy of heat and ice. The need for CPM is relegated to patients who fit a select group of post-operative individuals for which this patient also does not qualify."

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Thermacure Pad, purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 33. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Cold/Heat Packs

**Decision rationale:** The ThermoCare Contrast Compression Therapy unit provides sustained cold/heat/compression therapy. In regard to the request for the purchase of a ThermoCare pad, Occupational Medicine Practice Guidelines state that patients' at-home applications of heat or cold packs may be used before or after exercise and are as effective as those performed by a therapist. Within the submitted medical records available for review, there is no documentation of symptoms and findings consistent with a condition for which compression is indicated. Furthermore, there is no documentation of a rationale for the use of a formal cold/heat/compression therapy unit rather than the application of simple cold and heat packs at home. The medical necessity for ThermoCare unit rental was not established. Therefore, the currently requested purchase of a ThermoCare pad is also not medically necessary.

**Continuous Passive Motion, 30 day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** In regard to the request for a Continuous Passive Motion Machine (CPM), 30-day rental, California MTUS and ACOEM do not contain criteria for this treatment modality. ODG recommends postoperative use may be considered medically necessary, for 4 to 10 consecutive days (no more than 21), after total knee arthroplasty, anterior cruciate ligament reconstruction, and open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint. In the submitted medical records available for review, there was documentation that the injured worker had a total right knee arthroplasty on 7/10/2013 (over a year ago). Additionally, there was no documentation that the treating physician was recommending surgery to the left knee at the time of the request. Based on the documentation, the post-operative timeframe for which this treatment modality would be indicated has passed. Therefore, the currently requested Continuous Passive Motion, 30-day trial, is not medically necessary.

**Continuous Passive Motion Pad, purchase:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** In regard to the request for purchase of a Continuous Passive Motion Machine Pad, California MTUS and ACOEM do not contain criteria for this treatment modality. ODG recommends postoperative use may be considered medically necessary, for 4 to 10

consecutive days (no more than 21), after total knee arthroplasty, anterior cruciate ligament reconstruction, and open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint. In the submitted medical records available for review, there was documentation that the injured worker had a total right knee arthroplasty on 7/10/2013 (over a year ago). Additionally, there was no documentation that the treating physician was recommending surgery to the left knee at the time of the request. Based on the documentation, the post-operative timeframe for which this treatment modality would be indicated has passed. Therefore since the machine is not medically necessary, the Continuous Passive Motion Pad that is used to cover the machine is also not medically necessary.

**Thermacure Unit, 30 day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 33. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Cold/Heat Packs and Compression

**Decision rationale:** Official Disability Guidelines (ODG) Knee Chapter, Cold/Heat Packs and Compression