

<b>Case Number:</b>	CM14-0043425		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	10/26/2006
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	02/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2014

### 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 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 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 patient is a 49-year-old male with a date of injury of 10/26/2006. According to progress report 01/16/2014, the patient presents with chronic back, neck, and right hip pain. The patient was admitted to the emergency department with complaints of pain and stating that he ran out of his pain medication, Norco. Under physical examination, the treater notes "due to chronic complaint, the patient stated that he needs medication refill, physical examination was not performed in details. Musculoskeletal was remarkable for tenderness to palpation over all major joints of the body. No deformity, bruising, or swelling identified at this time." The list diagnoses are: 1. Chronic back pain. 2. Chronic pain. Orthopedic evaluation report from 09/10/2013 states that the patient is status post 6 weeks following right total knee replacement. Sensation was intact in all dermatomes. There are 2+ reflexes in the patellae and Achilles. Negative Achilles clonus and negative SLRs was noted. There is tenderness to palpation over the medial and lateral joint lines to the right knee. There is decreased range of motion in the right knee on all planes. The request is for bath chair, commode chair, wheelchair/walker, and CMP. The progress reports provided for review do not discuss these requests. Utilization review denied the requests on 02/26/2014. Treatment reports from 08/06/2013 through 01/16/2014 were provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bath chair:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Durable Medical Equipment (DME)

**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 (Acute & Chronic) Chapter, Bathtub seats, See Durable medical equipment (DME)

**Decision rationale:** This patient presents with chronic back, neck, and right hip pain. He is status post right total knee replacement on 09/26/2013. Current request is for bath chair. The medical file provided for review does not include a rationale for the requested bath chair. Utilization review denied the request stating that the patient is able to ambulate comfortably, and there is no support at this time for the requested bath chair. ODG has the following regarding "Bathtub seats" under Durable Medical Equipment, "Bathtub seats are considered a comfort or convenience item, hygienic equipment, & not primarily medical in nature." Shower/bath chairs or seats are not supported by ODG and the treating physician has provided no medical reasoning for this request. Treatment is not medically necessary and appropriate.

**3-1 Commode chair:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Durable Medical Equipment (DME)

**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 (Acute & Chronic) Chapter, Durable medical equipment (DME)

**Decision rationale:** This patient presents with chronic back, neck, and right hip pain. He is status post right total knee replacement on 09/26/2013. The current request is for 3-1 commode chair. The ACOEM and MTUS guidelines do not discuss commodes. ODG guidelines have the following under Durable Medical Equipment, "Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home." ODG does not support durable medical equipments such toilet supplies. ODG further discusses criteria for durable medical equipment as equipment that is primarily and customarily used to serve a medical purpose. The treater has not provided any medical reasoning for the requested 3-1 commode. Treatment is not medically necessary and appropriate.

**Front wheel walker:**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Walking Aids

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, walking aids

**Decision rationale:** This patient presents with chronic back, neck, and right hip pain. He is status post right total knee replacement on 09/26/2013. The current request is for a front-wheeled walker. ODG guidelines under its Knee Chapter has the following regarding walking aids. "Recommended for patients with conditions causing impaired ambulation, when there is a potential for ambulation with these devices." In this case, there is no description of impaired ambulation and examination finding do not document functional deficits that would require a walker. Treatment is not medically necessary and appropriate.

**Continuous passive motion (CPM) x 4 wks rental- soft goods and set up for the right knee:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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 (Acute & Chronic) chapter, Continuous passive motion (CPM)

**Decision rationale:** This patient presents with chronic back, neck, and right hip pain. He is status post right total knee replacement on 09/26/2013. The current request is for continuous passive motion (CPM) x4 weeks rental - Softgoods and setup for the right knee. The MTUS and ACOEM guidelines do not discuss continuous passive motion devices. Therefore, ODG guidelines were consulted. ODG under its knee and leg chapter has the following regarding Continuous Passive Motion (CPM) devices, "Recommended as indicated below, for in-hospital use, or for home use in patients at risk of a stiff knee, based on demonstrated compliance and measured improvements, but the beneficial effects over regular PT may be small. Routine home use of CPM has minimal benefit. Although research suggests that CPM should be implemented in the first rehabilitation phase after surgery, there is substantial debate about the duration of each session and the total period of CPM application." ODG further states the criteria for home use is "up to 17 days after surgery while patients at risk for a stiff knee are immobile or unable to bear weight." Indications include TKA, ACL reconstruction and ORIF of tibial plateau or distal femur fractures involving the knee joint. This patient is s/p right knee total knee replacement and the ODG guidelines do support the use of CPM following surgery. ODG guidelines provide specific timeframes for post operative use for "up to 17days after surgery." Treatment is not medically necessary and appropriate.