

<b>Case Number:</b>	CM14-0053310		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	10/02/2008
<b>Decision Date:</b>	08/12/2014	<b>UR Denial Date:</b>	03/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2014

### 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 Texas. 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 41-year-old female who reported an injury on 10/02/2008 after being hit with the back door of a van. The injured worker reportedly sustained an injury to the right knee and low back. The injured worker's treatment history included multiple surgical interventions for the right knee, physical therapy, a TENS unit, and a brace. According to the chart note dated 02/19/2014, the injured worker was recommended for total knee replacement. Physical findings at that appointment included a positive compression test with knee extension to 180 degrees with knee extension to 110 degrees on the right. The injured worker's diagnoses included internal derangement of the knee, left knee sprain, and right ankle sprain. A request was made for a continuous passive motion machine and postsurgical durable medical equipment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continuous Passive Motion (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 (ODG) ODG Knee & Leg (updated 01/20/14); continuous passive motion (CPM).

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

**Decision rationale:** The requested continuous passive motion machine is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not specifically address this request. The Official Disability Guidelines recommend continuous passive motion machine post surgically for total knee replacements. However, the request as it is submitted does not clearly define a treatment duration or whether the requested equipment is for rental or purchase. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested continuous passive motion machine is not medically necessary or appropriate.

**Hospital Bed for 1 month rental:** 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) Knee & Leg (updated 01/20/14) 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 and Leg chapter, Durable Medical Equipment (DME).

**Decision rationale:** The requested hospital bed for 1 month rental is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this type of request. The Official Disability Guidelines recommend durable medical equipment on a rental basis for patients with injury or illness that require medically necessary equipment. The clinical documentation submitted for review does not adequately provide justification for the need for a hospital bed. There is no documentation that the injured worker requires modification beyond what a normal bed could accommodate. As such, the requested hospital bed for 1 month rental is not medically necessary or appropriate.

**Bedside Commode:** 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) Knee & Leg (updated 01/20/14) 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 and Leg Chapter, Durable Medical Equipment (DME).

**Decision rationale:** The requested bedside commode is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker is a surgical candidate. However, the Official Disability Guidelines do not support the need for a bedside commode or environmental changes unless the injured worker is restricted to a single room and cannot functionally ambulate to a restroom. The clinical documentation submitted for review does not provide any evidence that the injured worker will be nonambulatory following

surgical intervention and would require a bedside commode. As such, the requested bedside commode is not medically necessary or appropriate.

**Commode elevated seat:** 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) Knee & Leg (updated 01/20/14) 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 and Leg Chapter, Durable Medical Equipment (DME).

**Decision rationale:** The requested commode elevated seat is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker is a surgical candidate. However, the Official Disability Guidelines do not support the need for a commode elevated seat or environmental changes unless the injured worker is restricted to a single room and cannot functionally ambulate to a restroom. The clinical documentation submitted for review does not provide any evidence that the injured worker will be nonambulatory following surgical intervention and would require a commode elevated seat. As such, the requested commode elevated seat is not medically necessary or appropriate.