

<b>Case Number:</b>	CM15-0184561		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	06/04/2004
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 67 year old female with a date of injury on 06-04-2001. The injured worker is undergoing treatment for osteoarthritis, localized, primary, involving the lower leg. A physician progress note dated 08-10-2015 documents the injured worker returns after six years with a history of longstanding knee pain, specifically medially. It has worsened over time. Symptoms are affecting her everyday life and activity. She is now retired from work. On examination she has carpus throughout range of motion. There is -4 extension and flexion to 110 degrees. She has a mild effusion noted. There is crepitus throughout range of motion and no ligamentous. X rays revealed complete joint space collapse of the medial compartment with level of degenerative joint disease in both lateral and patellofemoral joint. She has end stage arthritis. A total knee arthroplasty was recommended and she wishes to proceed. A physician note dated 08-18-2015 documents the injured worker has continued left knee pain with severe medial-sided knee osteoarthritis. She now wishes to continue with conservative care. A cortisone injection was administered. She will be followed up on an as needed basis for knee pain management. Voltaren gel and Naprosyn was given as adjunctive treatments for her knee arthritis pain. Treatment to date has included diagnostic studies, medications, and cortisone injections. The Request for Authorization dated 08-19-2015 includes a total left knee arthroplasty, assistant PA, Pre-op EKG, Labs, Medical clearance, CTU, CPM, front wheel walker, and 3-in-1 commode. On 09-14-2015 the Utilization Review non-certified the request for 3 in 1 Commode, a Cold therapy unit, Continuous Passive motion and a front wheel walker.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Continuous Passive Motion:** 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 (Acute & Chronic), 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) Knee & Leg (Acute & Chronic), Continuous passive motion (CPM).

**Decision rationale:** The Official Disability Guidelines do not recommend continuous passive motion machines for chronic pain. They are recommended 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. Criteria for the use of continuous passive motion devices: In the acute hospital setting, postoperative use may be considered medically necessary, for 4-10 consecutive days (no more than 21), for the following surgical procedures: (1) Total knee arthroplasty (revision and primary); (2) Anterior cruciate ligament reconstruction (if inpatient care); (3) Open reduction and internal fixation of tibial plateau or distal femur fractures involving the knee joint (BlueCross BlueShield, 2005) For home use, up to 17 days after surgery while patients at risk of a stiff knee are immobile or unable to bear weight: (1) Under conditions of low postoperative mobility or inability to comply with rehabilitation exercises following a total knee arthroplasty or revision; this may include patients with: (a) complex regional pain syndrome; (b) extensive arthrofibrosis or tendon fibrosis; or (c) physical, mental, or behavioral inability to participate in active physical therapy. (2) Revision total knee arthroplasty (TKA) would be a better indication than primary TKA, but either OK if #1 applies. The requested surgical procedure was not certified, consequently, the need for postoperative use of a continuous passive motion machine is not medically necessary.

### **Front Wheel Walker:** 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 Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

**Decision rationale:** According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including: There is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and There is documentation substantiating that the DME is

clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and The documentation supports that the requested DME will restore or facilitate participation in the individual's usual IADL's and life roles. The information should include the individual's diagnosis and other pertinent functional information including, but not limited to, duration of the individual's condition, clinical course (static, progressively worsening, or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The requested surgical procedure was not certified, consequently, the need for postoperative use of a Front Wheel Walker is not medically necessary.

**3 in 1 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), Durable Medical Equipment (DME).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

**Decision rationale:** According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including: There is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and There is documentation substantiating that the DME is clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and The documentation supports that the requested DME will restore or facilitate participation in the individual's usual IADL's and life roles. The information should include the individual's diagnosis and other pertinent functional information including, but not limited to, duration of the individual's condition, clinical course (static, progressively worsening, or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The requested surgical procedure was not certified, consequently, the need for postoperative use of a 3 in 1 commode is not medically necessary.

**Cold Therapy Unit:** 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), Continuous-flow cryotherapy.

**Decision rationale:** The Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. The requested surgical procedure was not certified, consequently, the need for postoperative use of a cold therapy unit is not medically necessary.