

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0010907 | | |
| Date Assigned: | 01/28/2015 | Date of Injury: | 06/12/2009 |
| Decision Date: | 03/31/2015 | UR Denial Date: | 01/14/2015 |
| Priority: | Standard | Application Received: | 01/20/2015 |

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 61 year old male who sustained an industrial injury on 06/12/2009. Diagnoses include end stage right knee osteoarthritis- medial compartment, status post partial knee replacement on 12/11/2014, and post-operative effusion and cellulitis. Treatment to date has included medications, physical therapy, and surgery. A physician progress note dated 12/17/2014 documents the injured worker was 6 days post-operatively. Pain level was 4/5 in severity. He went to the Emergency Room on 12/13/2014 due to severe knee swelling and drainage from the incision. Right knee has 2+ effusion, anterior incision is clean, dry and intact with extensive surrounding erythema and mild purulent discharge. Range of motion is limited. Treatment requested is for continues passive Motion (CPM) 30 Day rental, CPM Pad Purchase, Commode Chair, Mobile or Stationary, with Fixed Arms for purchase, Therma Core 30 day rental and Therma Core pad for purchase, Walker, Folding, Wheeled, Adjustable or Fixed Height. On 01/14/2015 Utilization Review non-certified the request for Therma Core 30 day rental and Therma core pad for purchase, and cited was MTUS ACOEM Guidelines. On 01/14/2015 Utilization Review non-certified the request for CPM 30 Day rental, CPM Pad Purchase, and cited was Official Disability Guidelines. On 01/14/2015 Utilization Review non-certified the request for, Commode Chair, Mobile or Stationary, with Fixed Arms for purchase, Walker, Folding, Wheeled, Adjustable or Fixed Height, and California Medical Treatment Utilization Schedule (MTUS), and Official Disability Guidelines do not specifically address this issue. The Medicare National Coverage Determinations Manual was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Therma Core 30 day rental and therma core pad for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg, Continuous-flow Cryotherapy

Decision rationale: The MTUS is silent on the use of cold therapy units. Per the ODG guidelines: "Recommended 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. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. The guidelines only support the use of cryotherapy devices for 7 days postoperatively. As the request is for 30 day rental, medical necessity cannot be affirmed.

CPM 30 Day Rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee Chapter

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

Decision rationale: The MTUS is silent on the use of CPM rentals. Per ODG TWC with regard to knee CPM: "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." 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 documentation submitted for review does not indicate that the injured worker meets any criteria for home use of CPM, furthermore, the request is in excess

of the 17 day recommendation set forth by the guidelines. The request is not medically necessary.

CPM Pad Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee Chapter

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

Decision rationale: As the requested CPM rental was not medically necessary, CPM pad purchase is not medically necessary.

Walker, Folding, Wheeled, Adjustable or Fixed Height for Purchase: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare National Coverage Determinations Manual

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg, Walking Aid

Decision rationale: With regard to walking aids, the ODG TWC states: "Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid." I respectfully disagree with the UR physician's assertion that the ODG does not address walking aids. Per citation above, walker is recommended as it was noted per 10/14/14 progress report that the injured worker's severe right knee pain interfered with his ADLs. He has failed nonoperative treatment with anti-inflammatories, use of a cane, physical therapy, and injections. The request is medically necessary.

Commode Chair, Mobile or Stationary, with Fixed Arms for purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare National Coverage Determinations Manual

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg, Durable Medical Equipment

Decision rationale: The MTUS is silent on the use of commode chairs. Per the ODG guidelines: Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in

the home. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. Certain DME toilet items (commodes, bed pans, etc.) are medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. The documentation submitted for review does not indicate that the injured worker is bed or room confined. There are no details regarding inability to use the commode. As such, medical necessity cannot be affirmed.