

<b>Case Number:</b>	CM15-0039987		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	07/05/2006
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 61 year old female with an industrial injury dated July 5, 2006. The injured worker diagnoses include osteochondral loose body, bilateral knee degenerative joint disease, status post total right knee arthroplasty, and lower back pain. She has been treated with diagnostic studies, radiographic imaging, prescribed medications, synvisc injection, physical therapy, and periodic follow up visits. According to the progress note dated 1/27/2015, the injured worker reported left knee and lower back pain. Objective findings revealed right knee crepitus and low back tight hamstrings with no focal radiculopathy. Left knee exam revealed crepitus, effusion, limited range of motion, medial joint line tenderness. The treating physician noted that the Magnetic Resonance Imaging (MRI) revealed tear meniscus and degenerative disc disease. The treating physician's treatment plan consists of MRI of the lumbar spine, synvisc injections for left knee, narcotic pain medications for left knee, and recommendations for total knee replacement of left knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**3 in 1 commode for home use (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) Durable medical equipment (DME) Durable medical equipment (DME).

**Decision rationale:** According to ODG guidelines, DME 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, bedpans, 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. Many assistive devices, such as electric garage door openers, microwave ovens, and golf carts, were designed for the fully mobile, independent adult, and Medicare does not cover most of these items. See also specific recommendations here: Aquatic therapy; Bathtub seats; BioniCare knee device; Bone growth stimulators; Braces; Canes; Cold/heat packs; Compression cryotherapy; Continuous-flow cryotherapy; Continuous passive motion (CPM); Crutches; Cryocuff; Cryotherapy; Dynamic splinting systems; Dynasplint; Electrical stimulators (E-stim); Electromyographic biofeedback treatment; ERMI knee Flexionater/ Extensionater; Flexionators (extensionators); Exercise equipment; Game Ready- accelerated recovery system; Home exercise kits; Joint active systems (JAS) splints; Knee brace; Lymphedema pumps; Mechanical stretching devices (for contracture & joint stiffness); Motorized scooters; Neuromuscular electrical stimulation (NMES devices); Orthoses; Post-op ambulatory infusion pumps (local anesthetic); Power mobility devices (PMDs); RS-4i sequential stimulator; Scooters; Shower grab bars; TENS (transcutaneous electrical nerve stimulation); Therapeutic knee splint; Treadmill exerciser; Unloader braces for the knee; Vacuum-assisted closure wound-healing; Vasopneumatic devices (wound healing); Walkers; Walking aids (canes, crutches, braces, orthoses, & walkers); Wheelchair; Whirlpool bath equipment. The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. (CMS, 2005) The patient suffered from knee and back injury that occurred on 2006. There is no justification from 3 to commode for home use in this case. There is no documentation how the commode will help with the patient condition. Therefore, the request is not medically necessary.

**Continuous passive motion (CPM) for home use (purchase):** 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 and leg.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Continuous passive motion (CPM).

**Decision rationale:** According to ODG Guidelines, continuous passive motion is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. See the Knee Chapter for more information on continuous passive motion devices. Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment. (Raab, 1996) (BlueCross BlueShield, 2005) An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. (Seida, 2010) Adhesive capsulitis: According to this RCT, CPM treatment for adhesive capsulitis provides better response in pain reduction than conventional physical therapy. The CPM group received CPM treatments for 1 h once a day for 20 days during a period of 4 weeks. The PT group had a daily physical therapy treatment including active stretching and pendulum exercises for 1 h once a day for 20 days during a period of 4 weeks. All patients in both groups were also instructed in a standardized home exercise program consisting of passive range of motion and pendulum exercises to be performed every day. In both groups, statistically significant improvements were detected in all outcome measures compared with baseline. Pain reduction, however, evaluated with respect to pain at rest, at movement and at night was better in CPM group. In addition, the CPM group showed better shoulder pain index scores than the PT group. (Dundar, 2009) Because adhesive capsulitis involves fibrotic changes to the capsuloligamentous structures, continuous passive motion or dynamic splinting are thought to help elongate collagen fibers. (Page, 2010) That is no rationale behind the use of shoulder CPM. There is no documentation that the patient is suffering from left shoulder adhesive capsulitis. Therefore, the request for Retrospective CPM plus soft goods x1 month rental dispensed 10/23/14 is not medically necessary.

**Front wheel walker for home use (purchase):** 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 and leg chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Walking aids (canes, crutches, braces, orthoses, & walkers), <http://www.worklossdatainstitute.verioiponly.com/odgtwc/knee.htm#Walkingaids>.

**Decision rationale:** According to ODG guidelines, wheeled walker is preferred for patients with bilateral disease. There is no clear evidence that the patient was approved for surgery. Therefore, the request for front wheeled walker is not medically necessary.

**Cold therapy (purchase):** 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 and leg chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.  
([http://www.worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#SPECT](http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT)).

**Decision rationale:** According to ODG guidelines, cold therapy is recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel. There is no evidence to support the efficacy of hot and cold therapy in this patient. There is not enough documentation relevant to the patient work injury to determine the medical necessity for cold therapy. There are no controlled studies supporting the use of hot/cold therapy in back post op pain beyond 7 days after surgery. There is no documentation that the patient needs cold therapy. Therefore, the request for Cold Therapy Unit for purchase is not medically necessary.