

<b>Case Number:</b>	CM15-0076859		
<b>Date Assigned:</b>	04/28/2015	<b>Date of Injury:</b>	07/05/2006
<b>Decision Date:</b>	06/29/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2015

### 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: Physical Medicine & Rehabilitation

### 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, who sustained an industrial injury on 7/5/06. The injured worker was diagnosed as having osteochondral loose body, degenerative joint disease of right knee and left knee, low back pain consequence of antalgic gait and lumbosacral radiculopathy. Treatment to date has included knee brace, physical therapy and Synvisc injections. Currently, the injured worker complains of worsening left knee pain with increasing back pain due to limping. Physical exam noted increased tightness of lumbar spine, left knee medial joint line tenderness with effusion and limited range of motion. The treatment plan included left total arthroplasty with requests for authorization for cold therapy unit, CPM machine, front wheeled walker and commode.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee chapter, under Continuous Passive Motion (CPM).

**Decision rationale:** The patient presents on 04/22/15 with unrated left knee pain and unrated lower back pain secondary to limping. The patient's date of injury is 07/05/06. Patient is status post total right knee replacement in July 2012, patient is currently awaiting total left knee replacement surgery. Per 04/22/15 progress note, this patient recently received IMR approval for the procedure following a series of UR denials/appeals. The request is for CPM FOR HOME USE (PURCHASE). The RFA is dated 04/22/15. Physical examination dated 04/22/15 reveals 4 to 111 degree range of motion of the right knee with crepitus, effusion and crepitus of the left knee. The progress note is primarily a discussion of this patient's case history and utilization review denials/appeals, no other positive physical findings are included. The patient's current medication regimen was not provided. Diagnostic imaging was not included, though progress note dated 04/22/15 references undated lumbar X-ray showing: "40% compression fracture at L1 of undeterminate [SIC] age." Patient's current work status is not provided. ODG Knee chapter, under Continuous Passive Motion (CPM), criteria for the use of continuous passive motion devices states: "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." In regard to the Continuous Passive Motion (CPM) machine for post-operative use, the provider has specified an excessive duration of therapy. This patient's anticipated surgical procedure would ordinarily meet the criteria for a CPM device post-operatively to reduce swelling, improve range of motion, and improve overall outcome. However, ODG guidelines only allow for 17 days of use following surgery; the request for a purchase of the device is excessive and cannot be substantiated. The request IS NOT medically necessary.

**Front wheel walker for home use (purchase):** Overturned

**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 knee chapter states the following about walking aids -canes, crutches, braces, orthoses, and walkers.

**Decision rationale:** The patient presents on 04/22/15 with unrated left knee pain and unrated lower back pain secondary to limping. The patient's date of injury is 07/05/06. Patient is status post total right knee replacement in July 2012; patient is currently awaiting total left knee replacement surgery. Per 04/22/15 progress note, this patient recently received IMR approval for the procedure following a series of UR denials/appeals. The request is for FRONT WHEEL WALKER FOR HOME USE (PURCHASE). The RFA is dated 04/22/15. Physical examination dated 04/22/15 reveals 4 to 111 degree range of motion of the right knee with crepitus, effusion and crepitus of the left knee. The progress note is primarily a discussion of this patient's case history and utilization review denials/appeals, no other positive physical findings are included. The patient's current medication regimen was not provided. Diagnostic imaging was not included, though progress note dated 04/22/15 references undated lumbar X-ray showing: "40%

compression fracture at L1 of undeterminate [SIC] age." Patient's current work status is not provided. ODG guidelines, knee chapter states the following about walking aids -canes, crutches, braces, orthoses, and walkers, "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." In regard to the 4 wheel walker to assist with this patient's ambulation, the request is appropriate. This patient is currently scheduled to undergo a total left knee replacement, a walker could prevent deterioration secondary to non-use, improve this patient's functional status and overall outcome. Therefore, the request IS medically necessary.

**3 in 1 commode for home use (purchase): Overturned**

**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 Pain chapter, DME.

**Decision rationale:** The patient presents on 04/22/15 with unrated left knee pain and unrated lower back pain secondary to limping. The patient's date of injury is 07/05/06. Patient is status post total right knee replacement in July 2012; patient is currently awaiting total left knee replacement surgery. Per 04/22/15 progress note, this patient recently received IMR approval for the procedure following a series of UR denials/appeals. The request is for 3 IN 1 COMMODORE FOR HOME USE (PURCHASE). The RFA is dated 04/22/15. Physical examination dated 04/22/15 reveals 4 to 111 degree range of motion of the right knee with crepitus, effusion and crepitus of the left knee. The progress note is primarily a discussion of this patient's case history and utilization review denials/appeals, no other positive physical findings are included. The patient's current medication regimen was not provided. Diagnostic imaging was not included, though progress note dated 04/22/15 references undated lumbar X-ray showing: "40% compression fracture at L1 of undeterminate [SIC] age." Patient's current work status is not provided. ODG Guidelines, under the durable medical equipment (DME) has the following: "durable medical equipment is defined as an equipment that is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. 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." In regard to the 3 in 1 commode for this patient's post-operative use, the request is appropriate. Progress note dated 04/22/15 indicates that this patient is currently awaiting total left knee replacement and will likely experience difficulties ambulating during the post-operative period. A commode for use at home will help mitigate this patient's post-operative pain and potentially improve her recovery. Therefore, the request IS 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee and Leg Chapter, under Continuous-flow cryotherapy.

**Decision rationale:** The patient presents on 04/22/15 with unrated left knee pain and unrated lower back pain secondary to limping. The patient's date of injury is 07/05/06. Patient is status post total right knee replacement in July 2012, patient is currently awaiting total left knee replacement surgery. Per 04/22/15 progress note, this patient recently received IMR approval for the procedure following a series of UR denials/appeals. The request is for COLD THERAPY (PURCHASE). The RFA is dated 04/22/15. Physical examination dated 04/22/15 reveals 4 to 111 degree range of motion of the right knee with crepitus, effusion and crepitus of the left knee. The progress note is primarily a discussion of this patient's case history and utilization review denials/appeals, no other positive physical findings are included. The patient's current medication regimen was not provided. Diagnostic imaging was not included, though progress note dated 04/22/15 references undated lumbar X-ray showing: "40% compression fracture at L1 of undeterminate [SIC] age." Patient's current work status is not provided. MTUS does not discuss Cold therapy, though ODG guidelines, Knee and Leg Chapter, under Continuous-flow cryotherapy states the following regarding postoperative cold therapy units: "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. Complications related to cryotherapy are extremely rare but can be devastating." In regard to the cold therapy unit purchase, the provider has exceeded guideline recommendations. Progress note dated 04/22/15 indicates that this patient is currently awaiting total left knee replacement, for which the cold therapy unit is to be used post-operatively. ODG specifies a 7-day rental for post-operative use, the request for a purchase exceeds this recommendation. Without an appropriate usage duration of use meeting guideline recommendations, the medical necessity cannot be substantiated. The request IS NOT medically necessary.