

<b>Case Number:</b>	CM14-0066341		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	11/24/2003
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	04/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/09/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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:

This is a patient with a date of injury of 11/24/03. A utilization review determination dated 4/18/14 recommends non-certification of lumbar spine MRI, total body technetium scan, and a motorized hospital bed. It references a 4/7/14 medical report identifying low back and bilateral knee pain, sensitive teeth, and temporomandibular joint dysfunction. There are complaints of chronic constipation with lower abdominal cramping, hemorrhoids, burning, and nausea with GERD (gastroesophageal reflux disease). There is a history of prior partial meniscectomies in both knees with some persistence of symptomatology that could be consistent with traumatic arthritis. A total body technetium bone scan was recommended to further assess the amount of increased wear. A lumbar MRI was also recommended. A motorized hospital bed was recommended with controls on both sides to allow one spouse to continue to sleep without affecting the other spouse.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine 1.5 Tesla Scanner or greater:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back procedure summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** Regarding the request for MRI of the lumbar spine, California MTUS does not specifically address repeat MRIs. ODG notes that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). Within the documentation available for review, there is no documentation of any significant change in symptoms/findings suggestive of significant pathology to warrant an updated lumbar spine MRI and no clear rationale for the request has been presented. In light of the above issues, the currently requested MRI of the lumbar spine is not medically necessary.

**Total body technetium scan:** 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), Low back procedure summary and Knee and leg procedure summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Bone scan (imaging).

**Decision rationale:** Regarding the request for Total body technetium scan, California MTUS and ACOEM do provide some support for bone scan of the knee for the evaluation of patellofemoral syndrome. ODG notes that it is recommended after total knee replacement in the evaluation of patients with Total knee arthroplasty (TKA) and pain and/or suspicion of loosening. Within the documentation available for review, there is no indication of a condition for which this study would be supported or a rationale for its use in a patient with suspected osteoarthritis, rather than standard radiography. In light of the above issues, the currently requested Total body technetium scan is not medically necessary.

**Motorized hospital bed model 10 split-king with flexible adjustable base and two protection mattress:** 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), Low back procedure summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Pain Chapter, Mattress selectionx Other Medical Treatment Guideline or Medical Evidence: [http://www.aetna.com/cpb/medical/data/500\\_599/0543.html](http://www.aetna.com/cpb/medical/data/500_599/0543.html).

**Decision rationale:** Regarding the request for a motorized hospital bed, California MTUS and ODG do not contain criteria for the purchase of a bed. ODG does state that there are no high-

quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. More specifically, Aetna notes that a hospital bed is supported when the patient's condition requires positioning of the body (e.g., to alleviate pain, promote good body alignment, prevent contractures, or avoid respiratory infections) in ways not feasible in an ordinary bed; or the condition requires special attachments (e.g., traction equipment) that can not be fixed and used on an ordinary bed; or it requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration, and pillows or wedges must have been considered. Within the documentation available for review, there is no documentation of any of the abovementioned conditions or another clear rationale identifying the medical necessity of a motorized hospital bed. In the absence of such documentation, the currently requested motorized hospital bed is not medically necessary.