

<b>Case Number:</b>	CM15-0017606		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	08/14/2012
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2015

### 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 57 year old male, who sustained an industrial injury on 8/14/12. On 1/29/15, the injured worker submitted an application for IMR for review of Crutches 10, and Hospital Bed, and Out Patient PT 3x Week for 6 Weeks and Pain Catheter. The treating provider has reported the injured worker complained of left knee pain with examination indicating medial joint tenderness with clicking and crepitus with surgery scheduled 1/28/15. The diagnoses have included status post left knee replacement, left knee meniscal tear, left knee internal derangement, left knee pain, left knee strain/sprain, hypertension and diabetes mellitus (diet controlled). Treatment to date has included right knee replacement surgery-rays and MRI left knee, medications. On 12/31/14 Utilization Review non-certified Crutches 10, and Hospital Bed, and Out Patient PT 3x Week for 6 Weeks and Pain Catheter. The MTUS, ACOEM and ODG Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hospital Bed:** 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, Durable Medical Equipment (DME).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AETNA guidelines has the following regarding the use of hospital bed.

**Decision rationale:** According to the 12/03/2014 report, this patient presents with "left knee pain." The current request is for Hospital bed but the treating physician's report and request for authorization containing the request is not included in the file. The patient's work status is "retired." Regarding hospital bed, Aetna guidelines states "hospital beds medically necessary" if the patient condition requires positioning of the body; e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections, in ways not feasible in an ordinary bed; or the patient 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 the patient's condition requires special attachments (e.g., traction equipment) that cannot be fixed and used on an ordinary bed. In reviewing of the provided reports, the treating physician does not document that the patient meets the criteria as required by the guidelines for a hospital bed. The request IS NOT medically necessary.

**Out Patient PT 3x Week for 6 Weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**Decision rationale:** According to the 12/03/2014 report, this patient is status post left knee replacement on 03/05/2014 and is outside of post-surgical time-frame and for therapy treatments. The current request is for outpatient PT 3 x weeks for 6 weeks but the treating physician's report and request for authorization containing the request is not included in the file. For physical medicine, MTUS guidelines pages 98, 99 state that for myalgia and myositis, 9-10 visits are recommended over 8 weeks. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Review of available records show no recent therapy reports and there is no discussion regarding the patient's progress. There is no documentation of flare-up or a new injury to warrant formalized therapy. The treater does not discuss the patient's treatment history or the reasons for requested additional therapy. No discussion is provided as to why the patient is not able to perform the necessary home exercises. MTUS page 8 requires that the treater provide monitoring of the patient's progress and make appropriate recommendations. In addition, the requested 18 sessions exceed what is allowed by MTUS guidelines. MTUS supports 8-10 sessions of physical therapy for this type of myalgia condition. The current request IS NOT medically necessary.

**Pain Catheter: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The National Institutes of Health.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines low back chapter: Implantable drug-delivery systems (IDDSs).

**Decision rationale:** According to the 12/03/2014 report, this patient presents with "left knee pain." The current request is for Pain catheter but the treating physician's report and request for authorization containing the request is not included in the file. MTUS and ACOEM Guidelines do not discuss intrathecal drug delivery systems. However, ODG Guidelines has the following in the pain section, which states, "Recommended only as an end-stage treatment alternative for selected patients for specific conditions after failure of at least 6 months of less invasive methods and following a successful temporary trial. Indications for implantable drug delivery system when it is used for the treatment of non-malignant pain with a duration of greater than six months and all of the following criteria are met: 1) Documentation in the medical records of failure of 6 months of other conservative treatment modalities, 2) Intractable pain secondary to a disease state with objective documentation of pathology, 3) Further surgical intervention or other treatment is not indicated, 4) Psychological lab evaluation had been obtained, 5) No contraindications to implantation, and 6) A temporary trial of spinal epidural or intrathecal opiates have been successful prior to permanent implantation with at least 50% to 70% reduction in pain." In this case, the treating physician provides no indication of the efficacy or lack of efficacy of the pain medication. In addition, there is no psychological evaluation and no objective documentation of a disease state with objective documentation of pathology. The current request IS NOT medically necessary.

**Crutches 10:** 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 Chapter, Walking Aids.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee /leg chapter : walking aides.

**Decision rationale:** According to the 12/03/2014 report, this patient presents with "left knee pain." The current request is for crutches 10. The treating physician does not explain why crutches are needed. Regarding crutches, ODG guidelines states "Recommended for patients with conditions causing impaired ambulation, when there is a potential for ambulation with these devices." Review of the provided reports show no documentation that the patient has a conditions causing impaired ambulation or recent surgery or injury. In this case, it is not known why crutches are needed and the treating physician does not provide medical rationale for the request. The request IS NOT medically necessary.