MAXIMUS Federal Services

Case Number:	CM14-0131459		
Date Assigned:	09/29/2014	Date of Injury:	04/09/2002
Decision Date:	11/14/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/18/2014

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 Orthopedic Surgery, 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 58 year old patient had a date of injury on 4/9/2002. The mechanism of injury was not noted. In a progress noted dated 7/29/2014, the patient is seen with regard to both knees and right elbow. She has hot and cold wrap and TENS unit is not working. Sitting tolerance is 45 minutes and standing tolerance is just a few minutes and lifting was no more than 10 pounds. On a physical exam dated 7/29/2014, there is tenderness along the joint line is noted on the left with weakness to resisted function. The plan is still working, and the doctor feels that total knee replacement at this time is reasonable. The diagnostic impression shows internal derangement of bilateral knees status post right total knee replacement and the left knee pain treated with injections in the past. She is doing physical therapy for knee strengthening and stabilization of the knees. Treatment to date: medication therapy, behavioral modification, TENS unitA UR decision dated 8/12/2014 denied the request for template measurement, stating that this patient is indicated for total knee replacement and this would be an inherent portion of X-ray measurement and/or pre-operative planning for the surgical construct. Hospital bed (months) was denied, stating the recommendation of specific sleeping surface or bed type has not been proven efficacious in studies. Polar care unit(days) was denied, stating guideline criteria have not been met due to complex surgery, and a cryotherapy unit is indicated for 7 days post-operative in a partial certification. Pain catheter (for long lasting pain relief) was denied, stating that there is no evidence of oral analgesics are not efficacious.

IMR ISSUES, DECISIONS AND RATIONALES

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

Template measurement: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines; Web-based version: Initial Assessment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter: pre-operative CT template http://www.intechopen.com/books/arthroplasty-update/preoperative-planning-of-total-knee-replacement

Decision rationale: CA MTUS does not address this issue. ODG states that three-dimensional CT is not recommended for routine preoperative templating in TKA; individual variation with 3-D modeling computed tomography scans may turn out to be worthwhile; their use is currently limited by their expense and debatable clinical significance. The patient is already indicated for left knee total knee replacement, but it is unclear which specific type of template is requested. A CT or MRI template would be inconsistent with current evidence. Therefore, the request for template measurement was not medically necessary.

Hospital Bed (months) X1: 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 (ODG) Knee and Leg Chapter - DME and Medicare National Coverage Determination Manual

Decision rationale: CA MTUS does not address this issue. ODG states that durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME). The Medicare National Coverage Determinations Manual criteria for a hospital bed include documentation that the patient's 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 that the patient's condition requires special attachments that cannot be fixed and used on an ordinary bed. However, in the documentation provided, there was no rationale provided regarding why this patient requires a specific type of bed, and why an ordinary bed cannot be tolerated. Furthermore, the time duration of "months" in this request is unclear, and needs to be specified. Therefore, the request for hospital bed (months) was not medically necessary.

Polar Care Unit (days) #21: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg chapter - Cryotherapy

Decision rationale: CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, this request does not specify the time frame for treatment. Therefore, the request for polar care unit (days) was not medically necessary.

Pain catheter (for long lasting pain relief): 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 (ODG) Shoulder Chapter - Pain Pumps

Decision rationale: CA MTUS does not address this issue. ODG does not recommend pain pumps. Three recent moderate quality RCTs did not support the use of pain pumps. There is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. In the documentation provided, there was no evidence that oral analgesics were not effective, and no rationale provided regarding the medical necessity of pain pumps when guidelines do not support it. Therefore, the request for pain pump (for long lasting pain relief) was not medically necessary.