

<b>Case Number:</b>	CM14-0163707		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	10/13/2000
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	09/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 Internal Medicine 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:

The injured worker (IW) is a 48 year-old male. The date of injury was 10/13/2000. He was injured in an MVA (motor vehicle accident) resulting in T6 paraplegia; neurogenic bladder/self catheterizations, and recurrent UTI's (urinary tract infections), status post colostomy. Type IDM (intensive diabetes management), and ESRD (end stage renal disease) leading to decreased donor renal transplant (DDRT) performed 2 years ago (August 5, 2011) complicated by CMV (Cytomegalovirus Infection) viremia and recurrent UTI's. Recent left hip osteomyelitis and left thigh swelling. He had a left ischium bone biopsy and culture on 4/25/14 consistent with osteomyelitis and culture positive for enterobacter cloacae, enterococcus faecalis, bifidobacterium species, and peptostreptococcus prevotii. He has no sensation below T6. He started IV ertapenem via PICC line for the confirmed L hip osteomyelitis. He noticed increased left thigh swelling so was seen in the ED 6/18/14 for evaluation. He was admitted and found to have a left femur fracture. He went to the OR 2 days later and had a retrograde intramedullary nail placed in left femur. Progress noted dated 8/27/14 indicating that the IW has recurrent sacral decubitus ulcers requiring multiple skin grafts with wound vac in place. Hyperbaric O2 was postponed when he was admitted for a spontaneous fracture of the left distal femur. The plan is to continue wound care and dressing changes. His immunosuppressant drugs are delaying the healing of his pressure ulcers. He is taking cellcept, cyclosporine, and prednisone. He currently has pressure ulcers in both ischia, the left hip, sacrum, both tibias, and the left heel. Per the 9/5/14 report, the IW did not have a foul odor or signs of necrosis in the areas that had ulcers.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **4 Subcutaneous debridements: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Clinical Guideline Center, Pressure ulcers: prevention and management of pressure ulcers. London (UK): National Institute for Health and Care Excellence, 2014 Apr. 37 p.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The peer-reviewed evidence-based guidelines for debridement are contained in the peer reviewed article: Pressure Ulcers: Prevention And Management Of Pressure Ulcers, April 2014, NICE Clinical Guideline 179; 37 pages.

**Decision rationale:** Subcutaneous debridement is not indicated at this time and consequently is not medically necessary. The California Medical Treatment Utilization Schedule and Official Disability Guidelines do not make any recommendations regarding the use of subcutaneous debridement treatment of pressure ulcers. The factors used to consider whether debridement of a pressure ulcer should take place include the following: 1) the amount of necrotic tissue; 2) the grade, size and extent of the pressure ulcer; 3) patient tolerance; and 4) any comorbidities. At the September 5, 2014 visit, there was moderate drainage noted from the pressure ulcers, but the discharge is mostly clear and serosanguinous. Additionally, there was no foul odor from the pressure ulcer. Although the injured worker is taking immunosuppressant drugs, there is no sign of infection in the pressure ulcers. In the absence of the necrotic tissue, necrotic drainage and the absence of foul-smelling wound drainage subcutaneous debridement is not medically necessary. A progress note from August 8, 2014 states the injured worker has not started hyperbaric oxygen. It was postponed as a result of the femur fracture. Hyperbaric oxygen treatment is beneficial and non-invasive for accelerated wound healing. That, along with physician office follow up is indicated. Based on the clinical information the medical record and the peer review, evidence-based guidelines subcutaneous debridement of the pressure ulcer is not medically necessary.

#### **4 Muscle debridements: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Clinical Guideline Center, Pressure ulcers: prevention and management of pressure ulcers. London (UK): National Institute for Health and Care Excellence, 2014 Apr. 37 p.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.nice.org.uk/guidance/cg179/resources/guidance-pressure-ulcers-prevention-and-management-of-pressure-ulcers-pdf>) and on the The peer-reviewed evidence-based guidelines for debridement appear in contained in the peer reviewed article: Pressure Ulcers: Prevention and Management of Pressure Ulcers, April 2014, NICE Clinical Guideline 179; pages 37.

**Decision rationale:** Muscle debridement is not indicated at this time and consequently is not medically necessary. The California Medical Treatment Utilization Schedule and Official Disability Guidelines do not make any recommendations regarding the use of muscle debridement of pressure ulcers. Alternative guidelines have been retrieved. The factors used to consider whether one should debride a pressure ulcer includes the following: 1) the amount of necrotic tissue; 2) the grade, size and extent of the pressure ulcer; 3) patient tolerance; and 4) any comorbidities. At the September 5, 2014 visit, there was moderate drainage noted from the pressure ulcers, but the discharge is mostly clear and serosanguinous. Additionally, there was no foul odor from the pressure ulcer. Although the injured worker is taking immunosuppressant drugs, there is no sign of infection in the pressure ulcers. In the absence of the necrotic tissue, necrotic drainage, the absence of foul-smelling wound drainage, in addition to the absence of frank infection in the pressure ulcer, muscle debridement is not medically necessary. Additionally, a progress note from August 8, 2014 states the injured worker has not started hyperbaric oxygen. It was postponed as a result of the femur fracture. Hyperbaric oxygen treatment is beneficial and non-invasive for accelerated wound healing. That, along with physician office follow up is indicated. Based on the clinical information the medical record and the peer review, evidence-based guidelines subcutaneous debridement of the pressure ulcer is not medically necessary.