

Case Number:	CM13-0030158		
Date Assigned:	03/17/2014	Date of Injury:	09/15/2005
Decision Date:	04/23/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	09/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in Maryland. 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 Physician 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 patient is a 53 year old male with a date of work injury 9/15/05. The diagnoses include: Status-post lumbar fusion (2005); right shoulder internal derangement; right knee internal derangement; cervical disc bulges; thoracic strain. Treatment has included: Left knee injection; 2005 lumbar fusion; left shoulder surgery x 2; 3/17/08 left knee surgery; physical therapy; acupuncture; chiropractic care; aqua therapy; home exercise program (HEP); epidural steroid injection; medications. There is a request for a purchase of a [REDACTED] automated massage chair and also a request for a purchase of a power wheelchair. A 4/9/13 primary treating physician progress report states that the patient complains of neck, upper back, bilateral shoulder, and bilateral knee pain. The neck pain radiates into both arms and the low back pain radiates into both legs. The pain is rated an 8 out of 10. He feels his condition is the same overall. He has numbness/tingling in both feet. His back pain and knee pain are associated with weakness in his legs. He reports that both knees buckle and pop with ambulation and transfers. Objective findings indicate a positive bilateral shoulder depressor test and a positive Becterew's test. The patient ambulates with a single point cane. There are requests for an infectious disease specialist for left knee pain. A consult with a surgeon for a possible left knee arthroplasty if there is no infection. There are requests for the [REDACTED] massage chair and for a power wheelchair due to chronic debilitation, low back and knee pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF [REDACTED] AUTOMATED MASSAGE CHAIR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Low Back, Neck & Upper Back: Massage.

Decision rationale: Purchase of a [REDACTED] automated massage chair is not medically necessary according to the MTUS and ODG guidelines. The MTUS guidelines indicate that massage therapy should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. There are scientific studies with contradictory results and many studies lack long-term follow up. Furthermore the MTUS guidelines indicate that massage is a passive intervention and treatment dependence should be avoided. There is no documentation that the employee has tried manual massage. There is no documentation of an adjunct treatment plan (i.e. home exercise program.). There is no documentation regarding which specific body part the chair is being used for. The ODG chapter on neck and upper back and also low back indicate that mechanical massage devices are not recommended. The request for a purchase of a [REDACTED] automated massage chair is not medically necessary.

PURCHASE OF POWER WHEELCHAIR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Power Mobility Devices (PMDs) Page(s): 99.

Decision rationale: A purchase of a power wheelchair is not medically necessary per the MTUS guidelines. The MTUS indicates that power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. There should be mobilization and independence encouraged throughout the injury recovery process. The guidelines furthermore indicate that if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. The documentation submitted does not reveal that the employee is unable to ambulate with a cane or walker or unable to manually propel a wheelchair. The request for purchase of a power wheelchair is not medically necessary.