

<b>Case Number:</b>	CM13-0032959		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	06/13/1994
<b>Decision Date:</b>	05/09/2014	<b>UR Denial Date:</b>	09/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2013

### 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 & Rehabilitation; has a subspecialty in Pain Medicine and is licensed to practice in Ohio and Texas 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 is a 53-year-old female who reported injury on June 13, 1994, the injury occurred when the injured worker slipped fell. The documentation from September 09, 2013 revealed that the injured worker continued to have complaints of daily bilateral knee pain and back pain. The diagnoses included cervical radicular/ulnar neuritis, osteoarthritis of the knee, and sprain to the lumbar region. The treatment plan included right knee aspiration and injection with cortisone, spine specialist, the injured worker requested a power wheelchair, hospital walker and pool therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **ONE (1) POWER WHEELCHAIR: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee and Leg, Power mobility devices (PMDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

**Decision rationale:** The California MTUS Guidelines indicate that a power mobility device is not recommended if the functional mobility deficit can be sufficiently resolved by the

prescription of a cane or walker; or if the patient has sufficient upper extremity function to propel a manual wheelchair; or there was a caregiver who was available, willing and able to provide assistance with a manual wheelchair. The clinical documentation submitted for review indicated additionally there was a request for a hospital walker. There was a lack of documentation of an objective examination to indicate the injured worker failed to have appropriate upper extremity function to propel a manual wheelchair. There was lack of documentation indicating the injured worker did not have a caregiver who was available, willing and able to provide assistance with a manual wheelchair. Given the above, the request for one (1) power wheelchair is not medically necessary.

**ONE (1) RIGHT KNEE ASPIRATION AND ULTRASOUND GUIDED INJECTION WITH CORTISONE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-346.

**Decision rationale:** The ACOEM Guidelines indicate that invasive techniques such as needle aspiration and fusions or prepatellar bursal fluid and cortisone injections are not routinely indicated. There was a lack of documentation of objective findings upon examination. There was a lack of a documented rationale indicating the necessity for a cortisone injection. Given the above, the request for one right knee aspiration and ultrasound-guided injection with cortisone is not medically necessary.

**A SPINE SPECIALIST CONSULTATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 289, 296, 305-306..

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

**Decision rationale:** The California MTUS Guidelines recommend a surgical consultation for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging (radiculopathy), preferably with accompanying objective signs of neural compromise, activity limitations due to radiating leg pain for more than one-month; or extreme progression of lower leg symptoms. Clear clinical, imaging and electrophysiological evidence of a lesion that has been shown to benefit in both short and long term from surgical repair and failure of conservative treatment to resolve disabling radicular symptoms should be present. The clinical documentation submitted for review failed to provide an objective physical examination and imaging studies. There was lack of documentation indicating the injured worker had activity limitations due to radiating leg pain and that the injured worker had clear clinical, imaging and electrophysiological evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. There was a lack of documentation of failure of

conservative treatment to resolve disabling radicular symptoms. Given the above, the request for a spine specialist consultation is not medically necessary.