

Case Number:	CM13-0048170		
Date Assigned:	12/27/2013	Date of Injury:	03/09/1998
Decision Date:	03/06/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	11/05/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a 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 and is licensed to practice in 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 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 71-year-old female who reported an injury on 03/09/1998. The mechanism of injury was not reported. The patient has been diagnosed with chronic low back pain, with intermittent radiculopathy, chronic neck pain markedly improved following an injection of the mid-scapular trigger point as well as cervical epidural steroid injection, chronic opiates with no evidence of physical dependence, tolerance, addiction, or pseudoaddiction; morbid obesity, post laminectomy syndrome lumbar, cervical facet syndrome, loss of biceps tendon reflex on the left, depression in remission, intermittent constipation in remission, and Coumadin prophylaxis. The clinical documentation indicated the patient was requesting a stair lift and scooter. The patient reported having difficulty ambulating between her weight and chronic pain. The patient is taking Zoloft, Colace, Soma, Neurontin, and Nucynta. The Soma has been decreased to one half of a 350 mg tablet every 6 hours as needed for muscle spasm. The patient has been recommended to continue the Zoloft, Colace, Neurontin, and Nucynta. The physical exam revealed decreased range of motion in the neck, status post surgery. The patient has been recommended aqua therapy 3 to 4 times per week for the neck and shoulders, a stair lift, and a scooter to be able to get around with her severe limitations from chronic low back pain, neck pain, and morbid obesity. The patient participated in 12 physical therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic Therapy 3-4 times a week for 8 weeks for neck: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter; <http://www.medicare.gov/Publications/Pubs/pdf/11045.pdf>;

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy, Physical medicine Page(s): 22,98.

Decision rationale: The Physician Reviewer's decision rationale: CA MTUS recommends aquatic therapy as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy, including swimming, can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home physical medicine. The patient continued to complain of chronic pain to the low back and neck. However, the physical therapy note indicated the patient had plateaued with physical therapy. Also, no documentation indicated the patient was participating in a home exercise program. Also, the request would exceed guideline recommendations regarding the number of sessions. Given the lack of documentation to support guideline criteria, the request is noncertified.

Stair Lift: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter; <http://www.medicare.gov/Publications/Pubs/pdf/11045.pdf>

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

Decision rationale: The Physician Reviewer's decision rationale: CA MTUS/ACOEM does not address the request. The Official Disability Guidelines state medical conditions that result in physical limitations for patients may require patient education and modification to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. Certain DME (toilet items, commodes, bedpans, etc.) are medically necessary if the patient is bed or room confined and devices such as raised toilet seats, commode chairs, sitz baths, and portable whirlpools may be medically necessary when prescribed as a part of medical treatment. The patient complained of neck and back pain. The patient has also been diagnosed as morbidly obese. However, no documentation was submitted indicating environmental modifications have been done to the patient's home. Given the lack of documentation to support guideline criteria, the request is noncertified.

Scooter: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter; <http://www.medicare.gov/Publications/Pubs/pdf/11045.pdf>;

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

Decision rationale: The Physician Reviewer's decision rationale: CA MTUS does not recommend power mobility devices, 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 wheelchair. The guidelines also state early exercise, mobilization, and independence should be encouraged throughout all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. The patient complained of pain to the neck and low back. However, the clinical documentation did not indicate that the patient could not use a manual wheelchair, cane, or walker. Given the lack of documentation to support guideline criteria, the request is noncertified.