

Case Number:	CM13-0056458		
Date Assigned:	12/30/2013	Date of Injury:	06/02/1993
Decision Date:	05/07/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/22/2013

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 and 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 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 64-year-old male who reported an injury on 06/02/1993. The mechanism of injury was not provided. Current diagnoses include status post left total knee arthroplasty, right shoulder residual bursitis and impingement, status post right shoulder surgery times 3, status post right knee TKA in 2012, and right shoulder glenohumeral degenerative joint disease. The injured worker was evaluated on 10/16/2013. The injured worker reported persistent right shoulder and bilateral knee pain. Physical examination revealed 0 to 120 degree range of motion of the right knee with painful patellofemoral crepitus, positive McMurray's testing, palpable tenderness along the medial and lateral joint lines, 4/5 strength, 0 to 110 degree range of motion of the left knee, 4/5 strength, 0 to 140 degree right shoulder range of motion, positive subacromial bursitis, positive impingement sign, intact sensation, and 4/5 strength in all quadrants. Treatment recommendations on that date included physical therapy twice per week for 3 weeks, a second opinion for ongoing interventional pain management, and a motorized scooter or a wheelchair.

IMR ISSUES, DECISIONS AND RATIONALES

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

A MOTORIZED SCOOTER OR 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 (ODG) Power Mobility Devices (PMDs)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES, (PMDs) Page(s): 99.

Decision rationale: California MTUS Guidelines state 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 injured worker has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available and willing to provide assistance with a manual wheelchair. The injured worker does not appear to meet criteria for the requested durable medical equipment. There is no documentation of a significant functional mobility deficit. There is also no indication that this injured worker does not maintain assistance from a caregiver to propel a manual wheelchair. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

A SECOND OPINION CONSULTATION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. As per the documentation submitted, there is no indication of an exhaustion of conservative treatment. The injured worker is pending authorization for physical therapy as well as injections. The injured worker has been instructed in a home exercise and stretching program. It was also previously noted in the documentation provided for review, the injured worker's current medication regimen was beneficial for pain relief and function. The medical necessity for a second opinion consultation has not been established. Therefore, the request is non-certified.

PHYSIOTHERAPY (6 SESSIONS): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. As per the documentation submitted, the injured worker has previously participated in a course of physical therapy. However, documentation of the previous course was not provided. Without evidence of

objective functional improvement, ongoing treatment cannot be determined as medically appropriate. There was also no specific body part or frequency listed in the current request. Therefore, the request is non-certified.

AN X-RAY OF THE BILATERAL KNEES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

Decision rationale: California MTUS/ACOEM Practice Guidelines state special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. As per the documentation submitted, the injured worker has previously undergone x-rays of bilateral knees in 02/2013. There is no documentation of a progression or worsening of symptoms or physical examination findings. There is also no mention of an exhaustion of conservative treatment prior to the request for additional imaging studies. Based on the clinical information received, the request is non-certified.