

Case Number:	CM13-0063654		
Date Assigned:	12/30/2013	Date of Injury:	05/25/2002
Decision Date:	05/13/2014	UR Denial Date:	11/11/2013
Priority:	Standard	Application Received:	12/10/2013

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 Preventive 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:

According to the records made available for review, this is a 56-year-old female with a 5/25/02 date of injury. On (9/17/13) there is documentation of subjective complaints of (worsening lower back pain, bilateral wrist/hand pain, and bilateral knee pain) and objective findings of (tenderness at the distal forearms and wrist bilaterally, increased pain upon passive stretching and resisted motion; tenderness over the first dorsal compartment at the A1 pulley, positive Tinel's, Phalen's and Finkelstein's tests, tenderness over the lumbar spine associated with hypertonicity and muscle guarding, decreased lumbar range of motion, bilateral knee swelling with tenderness and crepitus upon range of motion, positive McMurray's and patellofemoral compression/grind test, decreased sensation in the bilateral upper and lower extremities, and guarded ambulation utilizing a wheeled walker with a seat for assistance). Current diagnoses consist of (failed back surgery syndrome status post decompressive laminectomy from L3 -L5, status post bilateral wrist surgery with post-operative residuals and associated bilateral forearm and wrist tendinitis and left De Quervain's tenosynovitis, history of bilateral elbow cubital tunnel syndrome, status post right knee arthroscopy with post -operative residuals and associated arthralgia, weight gain secondary to inactivity, and fibromyalgia). Treatment to date includes (medications, lumbar surgery, wrist surgery, elbow surgery, and knee surgery).

IMR ISSUES, DECISIONS AND RATIONALES

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

POOL THERAPY (INITIALLY 8 VISITS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY. Decision based on Non-MTUS Citation ODG: AQUATIC THERAPY AND LOW BACK CHAPTER.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 114, Chronic Pain Treatment Guidelines AQUATIC THERAPY Page(s): 22.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that aquatic therapy is recommended where reduced weight bearing is desirable (such as extreme obesity), as criteria necessary to support the medical necessity of aquatic therapy. MTUS reference to ACOEM guidelines identifies importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those, as criteria necessary to support the medical necessity of physical modalities. ODG identifies visits for up to 10 visits over 8 weeks in the management of intervertebral disc disorders. Within the medical information available for review, there is documentation of diagnoses of failed back surgery syndrome status post decompressive laminectomy from L3-L5, status post bilateral wrist surgery with post-operative residuals and associated bilateral forearm and wrist tendinitis and left De Quervain's tenosynovitis, history of bilateral elbow cubital tunnel syndrome, status post right knee arthroscopy with post-operative residuals and associated arthralgia, weight gain secondary to inactivity, and fibromyalgia. However, despite documentation of weight gain, there is no documentation of an indication for which reduced weight bearing is needed (extreme obesity). Therefore, based on guidelines and a review of the evidence, the request for pool therapy (initially 8 visits) is not medically necessary.

ACUPUNCTURE (INITIALLY 6 VISITS): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: MTUS Acupuncture Medical Treatment Guidelines identifies that acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery, to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. In addition, MTUS Acupuncture Medical Treatment Guidelines allow the use of acupuncture for musculoskeletal conditions for a frequency and duration of treatment as follows: Time to produce functional improvement of 3 -6 treatments, frequency of 1 -3 times per week, and duration of 1-2 months. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of failed back surgery syndrome status post decompressive laminectomy from L3 -L5, status post bilateral wrist surgery with post-operative residuals and associated bilateral forearm and wrist tendinitis and left De Quervain's tenosynovitis, history of

bilateral elbow cubital tunnel syndrome, status post right knee arthroscopy with post-operative residuals and associated arthralgia, weight gain secondary to inactivity, and fibromyalgia. However, given documentation of a 5/25/02 date of injury, where there would have been an opportunity to have had previous acupuncture, it is not clear if this is a request for initial or additional acupuncture (where previous acupuncture may have already exceeded guidelines regarding a time-limited plan and there is the necessity of documenting functional improvement) Therefore, based on guidelines and a review of the evidence, the request for acupuncture (initially 6 visits) is not medically necessary.

PURCHASE OF POWER SCOOTER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES (PMDs) Page(s): 132. Decision based on Non-MTUS Citation ODG: ANKLE AND FOOT CHAPTER, POWER MOBILITY DEVICES (PMDs)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES Page(s): 132.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of a functional mobility deficit that cannot be sufficiently resolved by the prescription of a cane or walker, the patient has insufficient upper extremity function to propel a manual wheelchair, and there is no caregiver who is available, willing, or able to provide assistance with a manual wheelchair, as criteria necessary to support the medical necessity of power scooter. Within the medical information available for review, there is documentation of diagnoses of failed back surgery syndrome status post decompressive laminectomy from L3 -L5, status post bilateral wrist surgery with post-operative residuals and associated bilateral forearm and wrist tendinitis and left De Quervain's tenosynovitis, history of bilateral elbow cubital tunnel syndrome, status post right knee arthroscopy with post-operative residuals and associated arthralgia, weight gain secondary to inactivity, and fibromyalgia. However, despite documentation that the patient has difficulties ambulating for long distances due to lower extremity radicular complaints relative to failed back surgical syndrome, as well as post-operative right knee residuals, there is no documentation of functional mobility deficit that cannot be sufficiently resolved by the prescription of a cane or walker. In addition, despite documentation of s/p bilateral wrist surgery with post-operative residuals, associated bilateral forearm and wrist flexor greater than extensor tendinitis, and left DeQuervain's tenosynovitis with history of worsening, there is no (clear) documentation that the patient has insufficient upper extremity function to propel a manual wheelchair. Furthermore, there is no documentation that no caregiver is available, willing, and able to provide assistance with a manual wheelchair. Therefore, based on guidelines and a review of the evidence, the request for purchase of power scooter is not medically necessary.

HOME HEALTH CARE 12HR A /DAY FOR 7 DAYS A WEEK.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines HOME HEALTH SERVICES Page(s): 51. Decision based on Non-MTUS Citation ODG CHAPTER ON LOW BACK: HOME HEALTH SERVICES

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines HOME HEALTH SERVICES Page(s): 51.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and the patient is homebound on a part-time or intermittent basis, as criteria necessary to support the medical necessity of home health services. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of no more than 35 hours per week. Within the medical information available for review, there is documentation of diagnoses of failed back surgery syndrome status post decompressive laminectomy from L3 -L5, status post bilateral wrist surgery with post-operative residuals and associated bilateral forearm and wrist tendinitis and left De Quervain's tenosynovitis, history of bilateral elbow cubital tunnel syndrome, status post right knee arthroscopy with post -operative residuals and associated arthralgia, weight gain secondary to inactivity, and fibromyalgia. However, there is no documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and the patient is homebound on a part-time or intermittent basis. In addition, the proposed number of hours per week exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for home health care 12hr a /day for 7 days a week is not medically necessary.