

Case Number:	CM13-0066242		
Date Assigned:	01/03/2014	Date of Injury:	04/13/1993
Decision Date:	05/16/2014	UR Denial Date:	12/10/2013
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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 61 year old male with date of injury 4/13/93. The treating physician report dated 11/21/13 indicates that the patient presents with severe back pain, right shoulder pain and lower extremity wounds and ulcerations. The current diagnoses are: Bilateral shoulder, neck and back pain with chronic pain syndrome, bilateral lower extremity motor weakness especially right lower extremity paralysis and palsy secondary to spinal cord infarction ad paraplegia, right shoulder adhesive capsulitis and left knee degenerative joint disease; Obesity; Impaired mobility and ADLs; and lower extremity wound

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY, TWO (2) TIMES PER WEEK FOR SIX (6) WEEKS,: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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

Decision rationale: The patient presents with chronic pain affecting the lumbar spine, right shoulder and has a new onset of lower extremity wounds and ulcerations that have not responded

to oral antibiotics. The current request is for 12 sessions of physical therapy. Objective findings include swelling and redness to the right lower extremity and a large wound over the anterior shin that has dressing in place with some serosanguinous drainage noted on the dressing. The right shoulder range of motion is significantly limited and any internal rotation of abduction creates pain. The MTUS guidelines allow 9-10 therapy visits for myalgia and myositis. However, this patient presents with much more than myalgia/myositis/neuritis type of condition. The patient is paraplegic with shoulder pain and an ulcerated leg. The patient has mobility and transfer problems. The current request for 12 sessions of therapy would appear reasonable. Review of the reports does not show a recent therapy history. Recommendation is for authorization.

ACUPUNCTURE, TWO (2) TIMES PER WEEK FOR SIX (6) WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Review of the Acupuncture Medical Treatment Guidelines (AMTG) supports acupuncture with the time to produce functional improvement being 3 to 6 treatments at a frequency of 1 to 3 times per week and an optimum duration of 1 to 2 months. The treating physician in this case did not prescribe a specific duration of treatment and the request is for 12 visits which is not supported in the AMTG guidelines without functional improvement. Functional improvement requires significant change in ADL's, or improvement in work status and decreased dependence of other treatments. In this case the request is for 12 visits, which is not supported in the guidelines without first reporting functional improvement with 3-6 visits. Recommendation is for denial.

RIGHT SHOULDER SYNVISIC INJECTION: 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), Shoulder Chapter, Hyaluronic acid injections

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Hyaluronic acid injections

Decision rationale: MTUS does not address Synvisc (Hyaluronic acid injections). ODG guidelines state that the treatment is not recommended, based on recent research in the shoulder, plus several recent quality studies in the knee showing that the magnitude of improvement appears modest at best. The ODG guidelines do not recommend Synvisc injection of the shoulder. Recommendation is for denial.

ADJUSTABLE BED: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Mattress Selection.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Hospital Beds and Accessories, Number: 0543 Policy

Decision rationale: The current request is for adjustable bed. The MTUS guidelines and ODG guidelines do not address Adjustable Beds. The AETNA guidelines supports adjustable hospital beds if the patient requires positioning of the body to alleviate pain, promote good body alignment, prevent contracture, etc. This patient is paraplegic, has poor shoulder function and has a large leg ulceration with swelling of the leg. An adjustable bed is therefore medically necessary.

██████████ **GLYDER 32:** Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, DME

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee Chapter, Durable Medical Equipment.

Decision rationale: The applicable guidelines indicate that durable medical equipment can be medically necessary when it can withstand repeated use, and be rented and used by successive patients, is primarily used for a medical purpose, and is not useful for a person in absence of injury or illness. The current request is for a ██████████ Glyder 32. ██████████ 32 is a sliding board for bed transfers. This would fall under the definition of durable medical equipment. Given the patient's paraplegic condition, as well as leg ulceration and shoulder issues, the use of a transfer board is medically reasonable.

██████████ **M300 WITH FOUR (4) CASTERS AND TWO (2) DRIVE WHEELS:** Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Power Mobility Devices (PMDS).

Decision rationale: The current request is for a ██████████ M300 with four casters and two drive wheels. The MTUS guidelines do not support power mobility devices if the patient is able to use a cane or walker, or has sufficient upper extremity strength to use a manual wheel chair. This does not appear to be the case in this patient. Guidelines do support powered mobility device for this patient's clinical scenario. However, the reports show that the patient already has one. There is no information found in any of the treating physician's reports to indicate that the patient's current electric wheelchair is not functioning and there is no medical necessity found for the request of a ██████████ M300 power mobility device.

