MAXIMUS Federal Services

Case Number:	CM14-0018336		
Date Assigned:	04/18/2014	Date of Injury:	11/05/2008
Decision Date:	06/30/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	02/13/2014

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 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 injured worker is a 38-year-old male who reported an injury on 11/05/2008. The mechanism of injury was not provided for review. The injured worker's treatment history included a spinal cord stimulator with subsequent removal on 2 different occasions, cognitive behavioral therapy, physical therapy, aquatic therapy, chiropractic care, epidural steroid injections, and multiple medications. The injured worker's most recent evaluation was dated 12/23/2013. It was documented that the injured worker had continued pain complaints of the bilateral arms and bilateral lower extremities rated at a 9/10. It was noted that the injured worker was wheelchair bound due to an inability to bear weight secondary to increasing pain. Physical findings included tenderness to palpation over the lumbar spine with paraspinous musculature with muscle spasms and myofascial trigger points. It was documented that the injured worker had restricted range of motion of the lumbar spine. The injured worker's diagnoses included status post right subtalar ankle joint injury, status post attempted subtalar fusion, sprain/strain of the right wrist, sprain/strain of the left wrist, right hip greater trochanteric bursitis, complex regional pain syndrome of the right lower extremity, depression, and internal derangement of the left knee. The injured worker's treatment plan included motorized lift attachment to the injured worker's vehicle to assist with transportation of equipment to family functions, grocery shopping, and other out of home locations. The injured worker's treatment plan also included aquatic therapy, and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

AQUATIC PHYSICAL THERAPY FOR BILATERAL UPPER AND LOWER EXTREMITIES, 2 TIMES A WEEK FOR 5 WEEKS, QTY.10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: California Medical Treatment Utilization Schedule recommends aquatic therapy for injured workers who require a nonweight bearing environment participating in active therapy. The clinical documentation does indicate that the injured worker is unable to bear weight secondary to extensive pain complaints. However, the clinical documentation does indicate that the injured worker has previously participated in aquatic therapy. The efficacy of that therapy was not provided. Therefore, the need for continued aquatic therapy cannot be determined. As such, the requested Aquatic Therapy for the Upper and Lower Extremities, 2 times a week for 5 weeks, quantity 10 is not medically necessary or appropriate.

MOTORITZED SCOOTER LIFT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California, Medical Policy Durable Medical Equipment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter, Durable Medical Equipment (DME).

Decision rationale: California Medical Treatment Utilization Schedule does not address durable medical equipment. Official Disability Guidelines recommend durable medical equipment when it serves a medical purpose within the home. There is no documentation to support that the injured worker requires a motorized scooter within the home and is not able to use a manual wheelchair for mobilization. Additionally, durable medical equipment is primarily used to serve a medical purpose. There is no justification for a motorized scooter lift to serve a medical purpose for the injured worker. As such, the requested motorized scooter lift is not medically necessary or appropriate.

PAIN MANAGEMENT CONSULTATION, TREATMENT AND LONG TERM MEDICATION MANAGEMENT: 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), Pain Procedure

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Therapy Page(s): 78.

Decision rationale: The clinical documentation does indicate that the injured worker has been on multiple medications for an extended period of time that would benefit from pain management. Therefore, a consultation would be indicated. However, treatment and long term medication management would need to be determined based on the pain management evaluation. As such, the requested Pain Management Consultation Treatment and Long Term Medication Management is not medically necessary or appropriate.