

Case Number:	CM14-0156509		
Date Assigned:	09/26/2014	Date of Injury:	08/10/1993
Decision Date:	10/27/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	09/24/2014

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, Pain Management 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 65 years old female with an injury date on 08/10/1993. Based on the 08/12/2014 progress report provided by [REDACTED], the diagnosis is: 1. Left knee sprain (MRI scan dated 04/21/2013), chronic anterior cruciate ligament tear (X-ray dated 04/18/2001), complete loss of medial and patellofemoral joint space. 2. Right knee sprain secondary to compensatory overuse; X-ray dated August 12, 2014 revealed moderate to severe osteoarthritis with 2mm medial joint space. 3. Left foot plantar fasciitis with history heel spur. 4. Left ankle sprain. 5. Left wrist sprain and carpal tunnel syndrome. 6. Cervical spine sprain. 7. Thoracic spine sprain. 8. Lumbar spine sprain and left leg radiculitis; MRI scan dated 06/11/2014 revealing moderate to severe central canal stenosis at L4-L5. 9. Bilateral shoulder periscapular strain. 10. Weight gain, morbid obesity secondary to all of the above and history of brain tumor affecting the endocrine system and aggravating weight gain. According to this report, the patient complains of lower back pain radiating to the bilateral lower extremities with numbness and tingling to the feet. Pain is increased with walking and weight-bearing and decreased with medications and home exercise program. The patient also complains of severe bilaterally knee pain and has difficulty ambulating. The patient also complains of bilateral shoulder pain, left wrist pain, and neck pain; symptoms are decreased with medications and home exercise. Exam of the lumbar spine reveals tenderness to palpation with spasm over the paravertebral musculature and bilateral sciatic notches. Straight leg raise is positive. Range of motion is restricted. Decreased sensation in the bilateral lower extremities along the L5-S1 nerve root is noted. There were no other significant findings noted on this report. The utilization review denied the request on 09/16/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 08/12/2014 to 08/22/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Durable Medical Equipment - Scooter: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices (PMDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99.

Decision rationale: According to the 08/12/2014 report by [REDACTED] this patient presents with lower back pain radiating to the bilateral lower extremities with numbness and tingling to the feet. The treating physician is requesting DME scooter. Regarding Power Mobility Devices, MTUS guidelines state "Not recommended 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 manual wheelchair." Review of reports show no functional mobility deficit and no deficit of the upper extremity to not able to use cane or walker. MTUS further state "if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. Given the above the request is not medically necessary.

Lidoderm gel 3% 120mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the 08/12/2014 report by [REDACTED] this patient presents with lower back pain radiating to the bilateral lower extremities with numbness and tingling to the feet. The treating physician is requesting Lidoderm Gel 3% 120mg. Regarding Topical Analgesics, MTUS guidelines states Lidocaine is only allowed in a patch form and not allowed in cream, lotion or gel forms. In this case, the request is for Lidocaine gel which is not supported by MTUS. Given the above the request is not medically necessary.