

Case Number:	CM14-0041266		
Date Assigned:	09/10/2014	Date of Injury:	04/14/2010
Decision Date:	10/15/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	04/07/2014

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 Pain Management and 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 54-year-old female with an injury date of April 14, 2010. Based on a February 03, 2014 progress report provided by [REDACTED], the patient complains of left buttock pain. The patient is status post knee arthroscopy on August 22, 2013, status post left lumbar epidural steroid injection September 27, 2013 and status post greater trochanteric bursitis. Status post right C6, C7 epidural steroid injection with numbness persisting associated with tingling and neck pain 1/10. The patient can sit for up to 25 minutes. She has ongoing left hamstring and buttock, pain and spasm with over activity. She walks three times daily but can only manage 200 ft before buttock pain impedes. Pain is rated 3-7/10. The patient had a recent knee buckle with hyperextension injury/fall, which caused increased pain to her shoulders, elbow, and hamstrings. Physical Examination on March 03, 2014 the patient's straight leg raising test is positive on the left side in supine position and had tenderness over left Greater Trochanteric Bursa reproducing pain. Inspection of the neck revealed loss of lordosis. Range of motion is decreased: flexion 45 degrees and extension 25 degrees. Spurling's maneuver causes radicular symptoms on the left. The patient had tenderness in the paracervical muscles and trapezius. Diagnosis on March 03, 2014 by [REDACTED] included lumbago, chronic pain syndrome, cervicalgia and cervical disc degeneration. Diagnosis on March 04, 2014 by [REDACTED] include right knee internal derangement; left knee posttraumatic arthritis with knee revision (x2); left hamstring completely avulsed and incompetent from falls and tears; right hamstring partial tear; lumbar Degenerative Disc Disease and Degenerative Joint Disease with sprain; left lower extremity sciatica; cervical Degenerative Disc Disease, Degenerative Joint Disease, and upper extremity radiculopathy. [REDACTED] is requesting 1. Occupational therapy evaluation for home ergonomic2. Transportation assistance as needed; 3. Custom computer-generated seat cushion x 2; 4.

Wheelchair Van for 1-year; 5. Motorized wheel chair for 1 year; 6. Community center pool/gym membership for 1 year; 7. Septra DS 160/800mg, #30; 8. Avelox 400mg # 30; and 9. an MRI of the Right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational therapy evaluation for home ergonomics: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Low Back Chapter, Procedure Summary (Last updated 02/13/14), Ergonomic Interventions

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7: Independent Medical Examinations and Consultations, page(s) 127.

Decision rationale: The request is for Occupational therapy evaluation for home ergonomic. According to the report dated March 04, 2014, the patient continues to demonstrate her substantial fall risk. Braces have been marginally effective. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, page(s) 127 states: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." The patient may benefit from additional expertise. Therefore, the request is medically necessary.

Transportation Assistance (as needed): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter: Transportation (to & from appointments) and on the Non-MTUS AETNA guidelines on transportation: (www.aetna.com).

Decision rationale: The request is for Transportation assistance as needed. According to the report dated March 04, 2014, a motorized wheelchair will allow patient to get out of the house to therapy and possibly, in the not too distant future, to make it into modified duty. The Official Disability Guidelines recommended transportation to appointments in the same community for patients with disabilities preventing them from self-transport. According to the AETNA Guidelines, the cost of transportation primarily for and essential to, medical care is an eligible medical expense. The request must be submitted for reimbursement and the request should document that patient cannot travel alone and requires assistance of a nurse or companion. Progress report dated February 03, 2014 states that patient walks three times daily but can only manage 200 ft before buttock pain impedes. Treater's request per progress report dated February

03, 2014 can be used as evidence for medical necessity of request. However, review of reports do not document patient's need of assistance from a nurse or companion. In addition, request states transportation as needed. Reimbursable cost of transportation is primarily for medical care. The request does not meet guidelines and is therefore not medically necessary.

Custom Computer-Generated Seat Cushion (#2): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter: Ergonomics interventions.

Decision rationale: The request is for Custom computer-generated seat cushions. According to the report dated March 04, 2014, a custom computer generated seat cushion is to reduce bedsore and serious infection risk; she will need two cushions: 1 for the wheelchair and one for the regular chair. The Official Disability Guidelines state that ergonomics interventions are recommended as an option as part of a return-to-work program for injured workers. However, there is conflicting evidence for prevention, so case-by-case recommendations are necessary. This study concluded there was no good-quality evidence on the effectiveness of ergonomics or modification of risk factors in prevention of low back pain. The ACOEM Practice Guidelines state that whole-body vibration, such as that from motor vehicle and machinery operation, especially in the range of 4 to 8 cycles per second (but including 2 to 11 cycles per second), should be reduced as much as possible by mechanical damping or balancing of machinery and/or damping cushions and padding. The guidelines address requests pertinent to return to work ergonomic evaluations. The patient will not be exposed to whole body vibration, which would require damping cushions and padding. Furthermore, there is conflicting evidence for ergonomic intervention. Therefore, the request is not medically necessary.

Wheel Chair Van (for 1-year): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter: Transportation (to & from appointments) and on the Non-MTUS AETNA guidelines on transportation: (www.aetna.com).

Decision rationale: The request is for a Wheelchair Van for 1-year. According to the report dated March 04, 2014, this is needed for transport with wheel chair. The Official Disability Guidelines recommends transportation to appointments in the same community for patients with disabilities preventing them from self-transport. The AETNA Guidelines on transportation state that the cost of transportation primarily for, and essential to, medical care is an eligible medical expense. The request must be submitted for reimbursement and the request should document that

patient cannot travel alone and requires assistance of a nurse or companion. Progress report dated February 03, 2014 states that the patient walks three times daily but can only manage 200-ft before buttock pain impedes. The Official Disability Guidelines provide a discussion regarding Durable Medical Equipments (DME). It supports DME's for items generally not useful to a person in the absence of illness or injury, and is primarily used for medical purpose. In this case, a van would not be primarily for medical use. Therefore, the request is not medically necessary.

Motorized Wheel Chair (for 1-year): 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 (PMDs) Page(s): 99.

Decision rationale: The request is for Motorized wheel chair for 1-year. The California MTUS Guidelines state that power mobility devices (PMDs) are 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, a motorized scooter is not essential to care. A review of the reports has not documented the patient's ability to propel a manual wheelchair. Progress report dated February 03, 2014 states that patient walks three times daily but can only manage 200 ft before buttock pain impedes. Based on guidelines, the request for motorized wheelchair/scooter is not essential to care. Therefore, the request is not medically necessary.

Community Center Pool/Gym Membership (for 1-year): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Low Back Chapter, Procedure Summary (last updated 12/27/13), Gym Memberships

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Gym membership.

Decision rationale: The request is for a Community center pool/gym membership for 1-year. According to the report dated March 04, 2014, the patient is limited in her ability to handle standing and walking and has been substantially reclusive substantially due to her unstable left lower extremity hamstring avulsion and multiple falls. The California MTUS and ACOEM Practice Guidelines are silent regarding gym membership. However, the Official Disability Guidelines state that with unsupervised programs, there is no information flow back to the provider, so he or she can make changes in the prescription, and there may be risk of further injury to the patient. Gym memberships, health clubs, swimming pools, athletic clubs, etc., would not generally be considered medical treatment. A gym membership takes place at an unsupervised environment, that could expose patient to further risk of injury. The Official Disability Guidelines do not generally consider gym membership a medical treatment. Therefore, the request is not medically necessary.

Septra DS (160/800mg, #30): 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-TWC), Infectious Disease Chapter, Procedure Summary (last updated 02/21/14), Sulfamethoxazole-Trimethoprim (Bactrim, Septra)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Infectious Diseases Procedure Summary Sulfamethoxazole-Trimethoprim (Bactrim® , Septra®).

Decision rationale: The request is for Septra DS. The Official Disability Guidelines states that Sulfamethoxazole-Trimethoprim (Bactrim, Septra) is recommended as a first-line treatment for diabetic foot infections, osteomyelitis, chronic bronchitis, and cellulitis. A review of the reports does not document an indication for the requested medication. Therefore, the request is not medically necessary.

Avelox (400mg, #30): 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-TWC), Infectious Disease Chapter, Procedure Summary (last updated 02/21/14), Moxifloxacin

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC Infectious Diseases Procedure Summary: Moxifloxacin (Avelox®).

Decision rationale: The request is for Avelox. The Official Disability Guidelines states that Moxifloxacin (Avelox) is recommended as first-line treatment for diabetic foot infections, chronic bronchitis, and pneumonia (CAP). A review of the reports does not document an indication for the requested medication. Therefore, the request is not medically necessary.

An MRI of the Right Shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Shoulder Chapter, Procedure Summary (last updated 12/27/13), Indications for Imaging--Magnetic Resonance Imaging (MRI)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, indications for imaging.

Decision rationale: The request is for an MRI of the Right shoulder. According to the report dated March 04, 2014, the treating physician suspects probable myotendinous avulsion and tears

with recent fall, imposed on previous injury from fall. The Official Disability Guidelines states that the indications for a shoulder magnetic resonance imaging (MRI) include acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; and a subacute shoulder pain, suspect instability/labral tear. The patient is over 40; she had a fall and presents with cervicalgia. X-rays of elbow were taken on March 11, 2014 and revealed no fractures. The treating physician suspects avulsion and tear from the fall. Therefore, the request is medically necessary.