

Case Number:	CM14-0072704		
Date Assigned:	07/16/2014	Date of Injury:	11/30/1984
Decision Date:	09/23/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/19/2014

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 Nevada. 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 64 year-old female who was reportedly injured on 11/30/1984. The mechanism of injury is noted as a lifting/carrying injury. The most recent progress note dated 5/16/2014. Indicates that there are ongoing complaints of chronic neck, left upper extremity pain, and low back pain. The physical examination demonstrated cervical spine: generalized tenderness to palpation of the spinous processes, and occipital area. Moderate paraspinal muscle guarding the tenderness. Bilateral trapezius spasm and tenderness. Range of motion flexion 30, extension 30, bilateral side bending 10, lateral rotation 60. Hyper sensitivity bilaterally of the index, middle, and thumb. Left shoulder: positive generalized tenderness in the glenohumeral area as well as the acromioclavicular joint. Moderate trapezius spasm and tenderness. Limited range of motion. Weakness of abduction in both shoulders. Thoracic spine: positive spinous process tenderness in the mid--lower thoracic region. With muscle guarding and tenderness. Lumbar spine: slight loss of normal center of gravity with the center of gravity shifted forward. Minimal flat back deformity. Spinous process tenderness from L3-sacrum. Moderate paraspinal muscle guarding the tenderness. Moderate guarding of movement. Slight sciatic notch tenderness bilaterally. Decreased range of motion. Generalized weakness of both upper extremities. Water licensed weakness bilaterally. No recent diagnostic studies are available for review. Previous treatment includes cervical and lumbar surgery, medications, and conservative treatment. A request was made for home healthcare 2 times a week for hours per day, electrical scooter, Cartivisc 500/200/150 mg #90, Restone 3/10mg #30, and was not certified in the pre-authorization process on 4/29/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Health Care 2 times a week for four hours per day: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: According to California Chronic Pain Medical Treatment Guidelines the criteria for home health services includes that the injured employee's homebound on at least a part-time or intermittent basis. A review of the attached medical records does not indicate that the injured employee is homebound. Therefore this request for home health services is not medically necessary.

Purchase of an electrical scooter: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Power Mobility Devices.

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 (Acute and Chronic) Power Mobility Device. Updated 8/25/2014.

Decision rationale: Official Disability Guidelines state power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or Walker. If the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available and willing and able to provide assistance with a manual wheelchair. Review of the medical records provided it is noted the patient did have generalized weakness of both upper extremities, but there was no documentation of inability to ambulate or weakness that is so extreme that cannot operate a manual wheelchair. Therefore according to guidelines this request is deemed not medically necessary.

Cartivisc 500/200/150 mg Quantity 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

Decision rationale: Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Despite multiple control clinical trials of glucosamine and osteoarthritis, controversy on efficacy related to symptomatic improvement

continues. Differences in results originate from the differences products, study design and study population. Therefore without strong evidence-based clinical trials, this request is deemed not medically necessary.

Restone 3/10mg Quantity 30: 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 Official Disability Guidelines (ODG) Pain (Chronic) Medical Food. Updated 9/10/2014.

Decision rationale: Official Disability Guidelines recommend medical foods as indicated below. They medical food is a food which is formulated to be consumed or administered internally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. After review of the medical documentation provided as well as the above stated guidelines this medication does not meet guideline criteria. Therefore this request is deemed not medically necessary.