

Case Number:	CM14-0083161		
Date Assigned:	07/21/2014	Date of Injury:	11/16/1978
Decision Date:	08/28/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/05/2014

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 71-year-old male who was reportedly injured on 11/16/1978. The mechanism of injury was noted as an industrial injury. The most recent progress notes dated 3/26/2014 and 4/24/2014 indicated that there were ongoing complaints of chronic back pain and shoulder pain. Physical examination demonstrated a right above knee amputation and the claimant used a motorized scooter independently. Shoulder range of motion restricted in all directions bilaterally, especially with abduction. Left was approximately 50% less than normal and right approximately 75% less than normal. Lumbar spine range of motion elicited pain. Flexion was limited to 75. Lumbar rotation was not possible and the claimant was unable to sit fully upright. There was also tenderness over lateral hips, entire left shoulder, anterior right shoulder, posterior neck and lumbosacral spine. There were also dysesthesia over lateral shoulder, arm, forearm, hand, right stump, and posterolateral left leg and lateral foot. Lumbar magnetic resonance image (MRI), dated 8/8/2011, demonstrated degenerative disc disease at all lumbar levels and bilateral foraminal stenosis at L3-L4, L4-L5 and L5-S1 (per progress note, MRI report not available). Previous treatment included bilateral hip bursa steroid injections, lumbar injections & radiofrequency ablation, and medications to include Lidoderm 5% patch Percocet 10/325mg and Neurontin. A request was made for occupational therapy times 2, retro meds (unspecified), and nurse case manager, assistance with activities of daily living, which was not certified in the utilization review on 5/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational Therapy x 2 (unspecified): Overturned

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

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

Decision rationale: The medical records document a request for two occupational therapy visits with evaluation and future treatment recommendations to reduce daily pain exacerbated by activities of daily living and maximize safety by providing evaluation and essential fall risk education and prevention, as well as durable medical equipment recommendations. The injured workers' history of a right above the knee amputation renders him a fall risk but is not related to his old workmen's compensation injury. California Medical Treatment Utilization Schedule guidelines support occupational therapy and physical medicine for chronic pain due to myalgia, myositis and neuralgia. As such, the request is considered medically necessary.

Retro Meds (unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 1-127.

Decision rationale: California Medical Treatment Utilization Schedule supports various anti-inflammatory and pain medications for the treatment of chronic pain. However, the clinical documentation failed to document what medications are being requested. As such, this request is not medically necessary.

Nurse Case Manager/ Assistance with ADL's: Upheld

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

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

Decision rationale: California Medical Treatment Utilization Schedule guidelines do not support full-time home health services to assist with activities of daily living. As such, this request is not medically necessary.