

Case Number:	CM14-0208069		
Date Assigned:	12/22/2014	Date of Injury:	07/19/2012
Decision Date:	02/28/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 50 year old male patient who sustained a work related injury on 7/19/12. The exact mechanism of injury was not specified in the records provided. The current diagnoses include right knee pain, neck pain, cervical disc disease, cervical radiculitis and right shoulder pain and status post right knee arthroscopy, chondroplasty patellofemoral joint and medial femoral condyle and medial meniscal debridement. Per the doctor's note dated 11/7/14, patient has complaints of neck pain, upper back pain, low back pain, right shoulder pain and right knee pain, with tingling sensation in the left hand and pain was 7-8/10 without the pain medications and 5-6/10 with the pain medications. Physical examination revealed right shoulder active range of motion: flexion 0-95 degrees and abduction 0-95 degrees; right knee active range of motion: 20 degrees of extension lag. flexion is up to 100 degrees; right knee was slightly swollen; healed arthroscopic scars in the right knee; tenderness on the medial joint line of the right knee; SLR caused low back pain and knee pain bilaterally; strength: 5/5 for the left upper and lower extremities, weakness in the right upper extremity and right lower extremity, reflexes: 1 + for both biceps and triceps, 2+ for both lower extremities and ambulates with a standard cane with an antalgic gait. On 11/17/14 he had right knee pain, crepitus, and tenderness on palpation. He was recommended a TKR that was not certified. The current medication lists include clonazepam, Latuda (lurasidone), Vibryd (vilazodone) and Lamictal. The patient has had right knee MRI report dated January 24, 2013, that revealed resolution of small nodular T2 hyperintense focus; EMG/NCV on September 13, 2013 revealed right C7 radiculitis and mild bilateral CTS; MRI of the cervical spine that revealed foraminal narrowing; MRI of the right shoulder that revealed

degenerative changes. The patient's surgical history includes status post right knee arthroscopy, chondroplasty patellofemoral joint and medial femoral condyle and medial meniscal debridement on July 31 2013; right CTR performed on 4/30/14. He has undergone 3 hyaluronic injections with minimal relief and cortisone injection in the right shoulder. The patient has received an unspecified number of PT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shower Chair: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (updated 01/30/15) Durable medical equipment (DME).

Decision rationale: ACOEM/MTUS do not address this request. Therefore, ODG used. He was recommended a TKR that was not certified. Any evidence of recent surgery was not specified in the records provided. There is no high grade scientific evidence for purchase of a Shower Chair for low back pain. The rationale for a Shower Chair was not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient. Detailed response to previous conservative therapy was not specified in the records provided. Previous conservative therapy notes were not specified in the records provided. The medical necessity of the request for a Shower Chair is not fully established in this patient.