

Case Number:	CM15-0023367		
Date Assigned:	02/13/2015	Date of Injury:	01/30/2013
Decision Date:	03/30/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	02/08/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 53 year old female, who sustained a work related injury on 1/30/13 when she leaped down two stairs at a school where she worked and developed left hip pain. She has reported symptoms of left hip pain that was a 4/10. Prior medical history included arthritis. The diagnoses have included trochanteric bursitis and enthesopathy of left hip. Treatments to date included topical creams, conservative treatment, physical therapy, acupuncture, injections, and medication. Diagnostics reported on 8/9/11: C5-7 disc degeneration, facet and uncovertebral joint arthropathy, bony impingement on the neural foramina bilaterally at these levels. The EMG/NCV was normal. Examination on 10/22/14 noted normal lordosis, tenderness to palpation on the left lumbosacral region. No tenderness to palpation along the S1 joint or greater trochanter but slight tenderness along the left trochanteric bursa. There was normal tone with no paraspinal muscle spasms. There was full range of motion, except for decreased range of motion with extension. No atrophy of quadriceps or gastrocnemius muscles. Reflexes were 2+ bilaterally. The straight leg test (bilaterally) was negative. There was a positive Patrick maneuver on the left side. A request was made for a mobility scooter, cushion, and massage chair. On 1/6/15, Utilization Review non-certified a Victory 10 four-wheeled mobility scooter, QTY: 1; Roho high profile cushion (16.75 x 18.5 x 4.25); Massage chair with L-type massage mechanism, noting the California Medical treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines (ODG).

IMR ISSUES, DECISIONS AND RATIONALES

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

Victory 10 four-wheeled mobility scooter, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99. Decision based on Non-MTUS Citation Hip & Pelvis &Knee; Powered Mobility Devices

Decision rationale: The chronic pain guidelines state the following regarding motorized wheel chairs: "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, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." Additionally, ODG comments on motorized wheelchairs and says the following: "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, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. (CMS, 2006) Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care." The treating physician states that the patient has full upper extremity strength and range of motion. The physician also indicates that the patient has no atrophy of the quadriceps, has a normal heel to toe walk and full range of motion of the lower extremities. There is no medical documentation that indicates that the patient cannot maneuver a manual wheelchair, cane or walker or that there is no caregiver available. As such, the request for Victory 10 four-wheeled mobility scooter, QTY: 1 is not medically necessary.

Roho high profile cushion (16.75 x 18.5 x 4.25): 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),

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back, Lumbar Support <http://www.ncbi.nlm.nih.gov/pubmed/23826832>

Decision rationale: ODG states "Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). Under study for post-operative use". ODG also states "Not recommended for prevention". A recent study of lumbar supports concluded "future work is required to determine clinical relevance over the long

term". The evidence based medicine only supports the use of lumbar supports with evidence of a compression fracture, spondylolisthesis, or documented instability. The treating physician has not provided documentation to meet ODG guidelines. As such, the request for Roho high profile cushion (16.75 x 18.5 x 4.25) is not medically necessary at this time.

Massage chair with L-type massage mechanism: 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), Low Back, Mattress selection; Dry hydrotherapy (hydromassage, aquamassage, water massage)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-30 and 308, Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Pain, Massage Therapy

Decision rationale: MTUS guidelines regarding low back complaints does not support massage as it has no proven efficacy in treating acute low back symptoms. MTUS and ODG state regarding massage therapy "This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases" and "Massage is a passive intervention and treatment dependence should be avoided." There is no indication from the treating physician as to the parameters for treatment or the length of treatment utilizing the massage chair. As such, the request for Massage chair with L-type massage mechanism is not medically necessary.