

Case Number:	CM15-0034256		
Date Assigned:	02/27/2015	Date of Injury:	02/23/2006
Decision Date:	04/14/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/23/2015

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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 57-year-old female who sustained a work related injury February 23, 2006, involving her right knee. Past history included gastritis, diverticulosis, and a psychiatric disorder not otherwise specified. According to a primary treating physician's progress report dated October 3, 2014, the injured worker presented as a follow-up for her past gastritis and constipation. The abdomen is soft with less tenderness. Sleep studies had been performed (present in medical record) and reveal periodic limb movements due to orthopedic pain. Treatment plan included continuing present medication, pain management consultation and advised against taking alka seltzer, narcotics and NSAIDS (non-steroidal anti-inflammatory drugs). There are no further current medical records available for review. According to utilization review dated January 30, 2015, the request for ██████████ Membership Continuation is non-certified, citing Official Disability Guidelines (ODG). The request for Massage Therapy for Right Knee (2 x 6) 12 Sessions is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for a Scooter is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

██████████ **membership continuation:** 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), Gym Membership.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee & Leg Chapter, Gym memberships.

Decision rationale: The patient presents with right knee pain. The request is for MEMBERSHIP CONTINUATION. The request for authorization is not provided. X-rays of the right knee and right tibia, date unspecified, shows no increase of osteoarthritis. The patient states that when walking her right foot goes to the right. The patient was approved for four sessions of massage therapy. Patient's medications include Hydrocodone/APAP, Orphenadrine Citrate, Diclofenac Sodium and Patoprazole Sodium. The patient is on modified work duty. MTUS and ACOEM guidelines are silent regarding gym membership. ODG, Knee & Leg Chapter, Gym memberships, states, "Not recommended as a medical prescription unless a home exercise program has not been effective and there is a need for equipment. Plus, treatment needs to be monitored and administered by medical professionals." Treater does not provide reason for the request. There is no documentation of specific need for special equipment and why the patient is unable to do the necessary exercises at home. MTUS does not support gym memberships unless there is a need for a special equipment to perform necessary exercises and adequate supervision/monitoring is provided. Furthermore, the treater does not document duration of membership in the request. Therefore, the request IS NOT medically necessary.

Massage therapy for right knee 2 x 6 (12 sessions): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

Decision rationale: The patient presents with right knee pain. The request is for MASSAGE THERAPY FOR RIGHT KNEE 2X6 (12 SESSIONS). The request for authorization is not provided. X-rays of the right knee and right tibia, date unspecified, shows no increase of osteoarthritis. The patient states that when walking her right foot goes to the right. The patient was approved for four sessions of massage therapy. Patient's medications include Hydrocodone/APAP, Orphenadrine Citrate, Diclofenac Sodium and Patoprazole Sodium. The patient is on modified work duty. The MTUS Guidelines page 60 on massage therapy states that it is recommended as an option and as an adjunct with other recommended treatments such as exercise and should be limited to 4 to 6 visits. Massage is a passive intervention and treatment, dependence should be avoided. Per progress report dated 07/24/14, treater's reason for the request is "to increase function, to help reduce the patient's pain and improving subsequent function to the right knee." The patient was previously authorized for four sessions of massage therapy. However, treater does not provide any documentation of treatment history.

Furthermore, the request for 12 additional sessions of massage therapy would exceed guideline recommendation for the patient's condition. Therefore, the request IS NOT medically necessary.

Scooter: 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 Power Mobility Devices Page(s): 99.

Decision rationale: The patient presents with right knee pain. The request is for SCOOTER. The request for authorization is not provided. X-rays of the right knee and right tibia, date unspecified, shows no increase of osteoarthritis. The patient states that when walking her right foot goes to the right. The patient was approved for four sessions of massage therapy. Patient's medications include Hydrocodone/APAP, Orphenadrine Citrate, Diclofenac Sodium and Patoprazole Sodium. The patient is on modified work duty. Power Mobility Devices under MTUS pg 99 states, "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." Treater does not provide reason for the request. There is no documentation of upper extremity issues where a cane, walker or manual wheelchair cannot be considered. MTUS allows for power mobility devices when cane, walker or manual wheelchair is not feasible due to upper extremity weakness. In this case, there is no indication that the patient does not have sufficient upper extremity function to use a cane, walker or manual wheelchair and that there is not a willing caregiver available for assistance. Therefore, the request IS NOT medically necessary.