

Case Number:	CM15-0055913		
Date Assigned:	04/01/2015	Date of Injury:	05/21/2009
Decision Date:	05/01/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/24/2015

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 65 year old female, who sustained an industrial injury on 05/21/2009. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having cervical strain, thoracic nine compression fracture, multilevel disc desiccation and bulging, left knee pain following arthroscopy with osteoarthritis, right knee meniscal tear, left ankle lateral synovitis and plantar fasciitis, head injury, status post left third digit hammer toe repair, and right shoulder pain. Treatment to date has included above listed procedures, weight loss program, use of an orthopedic mattress, use of an air stirrup splint, and use of exercise equipment. In a progress note dated 02/06/2015 the treating physician reports complaints of aching pain to the left shoulder, low back, and bilateral knees. The treating physician also noted tenderness to the cervical paraspinal muscles, bilateral trapezius muscles, lumbar paraspinal muscles, acromioclavicular joint, medial and lateral knee, and to the hamstring muscle on the right, along with spasms to the cervical spine with range of motion, and a positive impingement sign to the right shoulder. The treating physician requested a weight loss program, exercise equipment (new step exercise bike), and an orthopedic mattress with the treating physician noting that this requested equipment and program has helped the injured worker in the past.

IMR ISSUES, DECISIONS AND RATIONALES

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

Weight loss program: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation website, <http://www.ncbi.nlm.nih.gov/pubmed/15630109>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation AETNA website aetna.com/cpb/medical/data/1_99/0039.html Website <http://www.lindora.com/lhc-riteaid.aspx>.

Decision rationale: Based on the 02/06/15 progress report provided by treating physician, the patient presents with pain to left shoulder, low back and bilateral knees. The request is for weight loss program. Patient is status post left knee arthroscopy and left third digit hammer toe repair, unspecified dates. Patient's diagnosis per Request for Authorization form dated 02/09/15 includes right shoulder pain due to transfer, cervical strain, T9 compression fracture, multilevel lumbar disc desiccation and bulging, left knee pain, right knee lateral meniscal tearing, left ankle lateral synovitis and plantar fasciitis, head injury with required treatment, and obesity. Medications and previous treatments were not discussed in provided medical records. The patient is rendered permanent and stationary, but working, per treater report dated 02/06/15. MTUS Guidelines page 46 and 47 recommends exercise, but states that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. Neither MTUS, ODG, nor ACOEM have any say on the weight loss program. AETNA website aetna.com/cpb/medical/data/1_99/0039.html was referred. AETNA allows "medically supervised" weight loss program only if the patient has failed caloric restriction and physical activity modifications. The [REDACTED] weight program is a medically supervised program <http://www.lindora.com/lhc-riteaid.aspx>. Per progress report dated 02/06/15, the request is for [REDACTED] Health Clinic's 10 week "Lean for Life," medical weight loss program. Treater states "the patient is in need of weight loss program, which has helped her in the past." Patient presents with a diagnosis of obesity, and treater quotes [REDACTED] weight loss goals with MTUS guidelines. However, provided progress reports do not reveal any steps taken by the patient to achieve weight loss goals. There is no documentation of trialed and failed caloric restrictions with increased physical activities, either. Furthermore, physician-monitored programs are supported for those with BMI greater than 30, but exclude [REDACTED], or similar programs. Therefore, the request is not medically necessary.

Exercise equipment: new step exercise bike: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official disability guidelines Knee Chapter online for DME.

Decision rationale: Based on the 02/06/15 progress report provided by treating physician, the patient presents with pain to left shoulder, low back and bilateral knees. The request is for exercise equipment new step exercise bike. Patient is status post left knee arthroscopy and left third digit hammer toe repair, unspecified dates. Patient's diagnosis per Request for Authorization form dated 02/09/15 includes right shoulder pain due to transfer, cervical strain, T9 compression fracture, multilevel lumbar disc desiccation and bulging, left knee pain, right knee lateral meniscal tearing, left ankle lateral synovitis and plantar fasciitis, head injury with required treatment, and obesity. Medications and previous treatments were not discussed in provided medical records. The patient is rendered permanent and stationary, but working, per treater report dated 02/06/15. MTUS Chronic Pain Medical Treatment Guidelines, for exercise, pages 46-47 states: Recommended. There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. ODG-TWC guidelines, Knee Chapter online for DME states: Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below. The term DME is defined as equipment which:(1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients;(2) Is primarily and customarily used to serve a medical purpose;(3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. (CMS, 2005) Per progress report dated 02/06/15, treater states patient is in need of exercise equipment which has helped her in the past. While a stationary bike is a good way for the patient to exercise, it is not superior to other methods of exercise that can be accomplished without a stationary bike. The stationary bicycle does not appear to meet the ODG-TWC guideline definition of durable medical equipment. It is not primarily used to serve a medical purpose and can benefit a person in the absence of illness or injury. Furthermore, there is no discussion as to why the patient is unable to establish a home exercise program to manage her pain. Therefore, the request is not medically necessary.

Orthopedic mattress: 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 Chapter, Mattress Selection.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic Chapter, under Mattress Selection Knee & Leg Chapter, Under Durable Medical Equipment.

Decision rationale: Based on the 02/06/15 progress report provided by treating physician, the patient presents with pain to left shoulder, low back and bilateral knees. The request is for orthopedic mattress. Patient is status post left knee arthroscopy and left third digit hammer toe repair, unspecified dates. Patient's diagnosis per Request for Authorization form dated 02/09/15 includes right shoulder pain due to transfer, cervical strain, T9 compression fracture, multilevel lumbar disc desiccation and bulging, left knee pain, right knee lateral meniscal tearing, left ankle lateral synovitis and plantar fasciitis, head injury with required treatment, and obesity.

Medications and previous treatments were not discussed in provided medical records. The patient is rendered permanent and stationary, but working, per treater report dated 02/06/15. MTUS and ACOEM are silent on orthopedic beds. ODG-TWC, Low Back - Lumbar & Thoracic Chapter, under Mattress Selection states, "There are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Mattress selection is subjective and depends on personal preference and individual factors. On the other hand, pressure ulcers (e.g., from spinal cord injury) may be treated by special support surfaces (including beds, mattresses and cushions) designed to redistribute pressure. (McInnes, 2011)" ODG Knee & Leg Chapter, Under Durable Medical Equipment, states that DME is defined as equipment, which is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury. Per progress report dated 02/06/15, treater states "patient is in need of orthopedic mattress which has helped her in the past," but has not provided reason for the request. ODG does not support "any type of specialized mattress or bedding as a treatment for low back pain." There is no mention of pressure ulcers that would warrant a special support surface, either. Furthermore, ODG's definition of DME states that it must primarily be used for a medical purpose and not generally useful in the absence of an illness; and a mattress is routinely used for non-medical purposes and in the absence of illness. The request is not in accordance with guideline criteria. Therefore, the request is not medically necessary.