

<b>Case Number:</b>	CM15-0058283		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	10/27/2003
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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, Arizona  
 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 59 year old female, who sustained an industrial injury on 10/27/2003. The diagnoses have included lumbosacral spine degenerative disc disease; lower extremity radiculopathy; and bilateral knee chondromalacia. Treatment to date has included medications, diagnostic studies, acupuncture, physical therapy, and home exercise program. Medications have included Norco and Flector patches. A progress note from the treating physician, dated 10/09/2014, documented a follow-up visit with the injured worker. Currently, the injured worker complains of continued pain and discomfort in the lower back and lower extremities. Objective findings included ambulation with a walker; discomfort in the lower back paraspinal muscles and the anterior knees bilaterally; and discomfort with straight leg raise testing. The treatment plan has included the request for Norco 10/325 mg #60; Flector patch #30; Treatment nurse; Home evaluation modification; and Vehicle hand control modification. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine guidelines.

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

**Decision rationale:** California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The request as submitted failed to indicate the specific body part to be treated. Therefore, the request is not medically necessary.

**Acupuncture 2 times a week for 6 weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes 3 to 6 treatments. The current request for 12 sessions of acupuncture would exceed guideline recommendations. In addition, the request as submitted failed to indicate the specific body part to be treated. As such, the request is not medically necessary.

**Scooter; scooter lift:** 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 Page(s): 99.

**Decision rationale:** California MTUS Guidelines state power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or a walker, or the patient has sufficient upper extremity function to propel a manual wheelchair. In this case, the injured worker's physical examination revealed discomfort in the low back, discomfort with straight leg raising, and discomfort in the anterior knees bilaterally. There was no evidence of instability. The injured worker utilized a walker for ambulation assistance. The medical necessity for a power mobility device has not been established in this case. As such, the request is not medically necessary.

**Bathroom evaluation; provide handicap bathroom; shower stool:** 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 Official Disability Guidelines (ODG) Knee & Leg Chapter, Durable Medical Equipment.

**Decision rationale:** The Official Disability Guidelines recommend durable medical equipment if there is a medical need and if the device or system meet Medicare's definition of durable medical equipment. Certain durable medical equipment toilet items are medically necessary if the patient is bed or room confined, and devices such as commode chairs may be medically necessary when prescribed as part of a medical treatment plan. In this case, there was no documentation of a significant functional deficit upon examination. The medical necessity for a handicap bathroom and a shower stool has not been established in this case. Therefore, the request is not medically necessary.