MAXIMUS Federal Services

Case Number:	CM14-0123435		
Date Assigned:	09/24/2014	Date of Injury:	12/14/1990
Decision Date:	10/28/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	08/04/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 72-year-old male who reported injury on 12/04/1990. The mechanism of injury was not provided. The injured worker's diagnoses included cervical spondylosis, lumbar spondylosis and lumbar spinal stenosis. The injured worker's past treatments include medications and physical therapy. The injured worker's diagnostic testing was not provided. The injured worker's surgical history was not provided. On the clinical note dated 08/12/2014, the injured worker complained of back pain rated 1/10. The injured worker noted his pain is decreased by medication and elevation. The injured worker had positive tenderness to palpation of the lumbar paraspinous area, tenderness to palpation throughout the back, decreased range of motion all planes and tenderness to palpation of the thoracic paraspinous are. The injured worker's medications included tramadol hydrochloride tablets 50 mg 3 times a day, Anaprox DS 550 mg twice a day, continue Flexeril 7.5 mg twice a day. The request was for acupuncture 3 times 3, physical therapy 3 times 3, and electric wheelchair. The rationale for the request was not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 3 x 3: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines,Chronic Pain Treatment Guidelines Purposes of Acupunture.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture 3 times 3 is not medically necessary. The injured worker is diagnosed with cervical spondylosis, lumbar spondylosis and lumbar spinal stenosis. The injured worker complained of back pain rated 1/10. The California MTUS Guidelines states acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The guidelines recommend 1 to 3 times per week over 1 to 2 months with the time to produce functional improvement of 3 to 6 treatments. The requesting provider did not indicate the site in which acupuncture was to be utilized for. There is a lack of documentation which demonstrates that conservative care failed to provide relief. There is a lack of documentation of significant findings of neurological deficits on physical examination. There is a lack of documentation indicating whether the injured worker previously had acupuncture, as well as the efficacy of the therapy. The medical records lacked documentation that indicates significant objective functional deficits to warrant acupuncture. Additionally, the request does not indicate the site in which the acupuncture is to be performed

Physical Therapy 3 x 3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Physical Medicine.

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

Decision rationale: The request for physical therapy 3 times 3 is not medically necessary. The injured worker is diagnosed with cervical spondylosis, lumbar spondylosis and lumbar spinal stenosis. The injured worker complained of back pain rated 1/10. The California MTUS Guidelines recommend 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 guidelines recommend 9 to 10 visits over 8 weeks. The medical records indicated the injured worker had previous physical therapy; however, the medical records did not indicate the number of sessions and efficacy of the prior therapy. There is a lack of documentation to indicate significant objective functional deficits to warrant additional visits of physical therapy. Additionally, the requesting physician did not indicate the part of the body in which the physical therapy is to be performed. As such, the request for physical therapy 3 x 3 is not medically necessary.

Electric Wheelchair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Walking Aids

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), KNEE AND LEG, POWER MOBILITY DEVICES.

Decision rationale: The request for electric wheelchair is not medically necessary. . The injured worker is diagnosed with cervical spondylosis, lumbar spondylosis and lumbar spinal stenosis. The injured worker complained of back pain rated 1/10. The Official Disability Guidelines do not recommend 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, 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 recovery process and if there is any mobility with canes or other assistive device a motorized scooter is not essential to care. The injured worker's medical records lack documentation of significant objective functional deficits to warrant a mobility device. There was a lack of documentation indicating the injured worker is already using assistive devices. The requesting provider did not provide rationale for the electric wheelchair request. As such, the request for electric wheelchair is not medically necessary.