

Case Number:	CM15-0115556		
Date Assigned:	06/23/2015	Date of Injury:	04/11/2014
Decision Date:	07/31/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	06/15/2015

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: Pennsylvania, Ohio, 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 74 year old male who sustained an industrial injury on 04/11/2014. Mechanism of injury occurred when the injured worker was entering a car when the driver took off, resulting in the claimant falling backwards on to the left side of his body. Previously the injured worker has suffered an industrial injury lacerating his right lower leg and underwent subsequent reconstructive surgery. In addition he suffered a fall in December of 2014 and required surgery to his left leg and was hospitalized for one month and received rehabilitation for approximately one month. He is currently off work. Diagnoses include cervical radiculopathy, bilateral shoulder tendonitis, lumbar radiculopathy, bilateral hip tendonitis, lumbar radiculopathy rule out diffuse idiopathic skeletal hyperostosis versus ankylosing spondylitis. The injured worker also has a diagnosis of diabetes. Treatment to date has included diagnostic studies, medications, physical therapy, and acupuncture, use of a Transcutaneous Electrical Nerve Stimulation unit, and cold and heat. His medications include Tramadol, Tylenol, Ibuprofen, Nabumetone, Lidopro Ointment and Omeprazole. A physician progress note dated 04/30/2014 documents the injured worker complains of continuous pain in his neck which is sharp, and travels to his bilateral shoulder blades, and he has numbness and tingling in his bilateral shoulders and arms. He has headaches, he has continuous pain in his bilateral shoulders and he has popping, clicking and grinding sensation in the shoulder. The injured worker has continuous pain in his lower back, which travels to his bilateral legs. He has episodes of numbness and tingling in his bilateral legs. He has lost his balance and fallen due to weakness in his back and hips. There is intermittent pain in his bilateral hips. His pain causes difficulty sleeping. His pain medications do help with the pain but he is still symptomatic. He has cervical spasm and tenderness over the paravertebral musculature and upper trapezium. There is decreased sensory

in the C5 and C6 on the right and left. Bilateral shoulder range of motion is restricted. Impingement and Hawkins signs were positive bilaterally and Jobe's sign was positive on the left. Apprehension test and re-location were positive on the left. Lumbar examination showed tenderness and spasm. Hip range of motion is normal. Treatment requested is for Motorized scooter purchase, Neurodiagnostic studies of the lower extremities, and Neurodiagnostic studies of the lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x 12 lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

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

Decision rationale: MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. This request is not medically necessary.

Motorized scooter purchase: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee/Power Mobility Devices.

Decision rationale: ODG supports the use of power mobility devices if a patient has a mobility impairment which cannot be addressed with a manual wheelchair or gait aid. In this case the records do not clearly document clinical reasoning as to why this patient could not use such a manual device. Thus the indication or rationale for this request is not clear and the request is not medically necessary.

Neurodiagnostic studies of the lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: MTUS/ACOEM recommend electrodiagnostic studies of the lower back/lower extremities if to evaluate specific neurological symptoms/findings, which suggest a neurological differential diagnosis. The rationale or differential diagnosis for the currently requested electrodiagnostic study are not apparent. This request is not medically necessary.