

Case Number:	CM15-0179282		
Date Assigned:	09/21/2015	Date of Injury:	04/16/1993
Decision Date:	12/04/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/11/2015

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, Pain Management

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 76 year old female, who sustained an industrial injury on April 16, 1993. The initial symptoms reported by the injured worker are unknown. The injured worker was currently diagnosed as having lumbar radiculopathy, cervical radiculopathy, right shoulder arthralgia status post arthroscopy, multilevel HNPs of the lumbar spine with stenosis, multilevel HNPs of the cervical spine with stenosis, degenerative disc disease of the cervical and lumbar spine, right S1 radiculopathy and recurrent falls. Treatment to date included diagnostic studies, injections, chiropractic treatment and medications. The injured worker was noted to have had chiropractic treatment over two years ago. Chiropractic treatment was reported to provide benefit with decreased pain and increased range of motion. On July 29, 2015, the injured worker complained of stabbing pain along the low back rated as a 7 on a 1-10 pain scale. She also reported burning, numbness, cramping and pins and needles in the bilateral feet. She has aching, burning pain along the left hip and burning, aching pain radiating through the left leg almost to her foot. The injured worker reported having difficulty rising from a seated position. Physical examination revealed diffuse tenderness to palpation to the cervical, thoracic and lumbar paraspinals. Range of motion of the cervical, thoracic and lumbar spines was "significantly decreased" in all planes. Straight leg raise test was positive bilaterally at 40 degrees to the foot. Slump was positive bilaterally to the foot. Her Norco medication was noted to reduce pain from an 8 on a 1-10 pain scale to a 6 on the pain scale. The treatment plan included a motorized wheelchair, in-home health care once a day for four hours, chiropractic rehabilitative therapy two times a week for four weeks to the cervical and lumbar spine, a lift chair, Ultracet, Norco,

Clonazepam and a follow-up visit. On August 20, 2015, utilization review denied a request for chiropractic rehab therapy quantity of eight, in-home health care one day a week for four hours with help with activity of daily living, motorized wheelchair, ongoing care for general orthopedic complaints, follow-up in eight weeks and a lift chair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic rehab therapy qty: 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: Regarding the request for chiropractic care, the Chronic Pain Medical Treatment Guidelines state on pages 58-60 the following regarding manual therapy & manipulation: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care: Not medically necessary. Recurrences/flare-ups: Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines: a. Time to produce effect: 4 to 6 treatments b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. In the case of this injured worker, there is no comprehensive summary of chiropractic to date or functional benefit from prior chiropractic treatment. Given the remote date of injury it is likely that this has been trialed at some point in the past, but the progress notes do not address this. If this is an initial request, then it exceeds guideline recommendation which specify for an initial trial of up to 6 visits. Given these factors, this request is not medically necessary.

In-home health care one a day week for four hours with help with activity of daily living qty: 1: 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), Pain section, Home health services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

Decision rationale: Regarding the request for home health care, California MTUS states that home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, and medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Within the documentation available for review, there is no documentation that the patient is in need of specialized home care (such as skilled nursing care, physical, occupational, or speech-language therapy). The guidelines recommend home health services for medical treatment such as the need for skilled nursing; it is not recommended when the only need is assistance with ADLs. The progress notes from 4/20/15 and 7/29/15 document functional impairment in ADLs and that the request is for the purpose of assisting the patient with cooking and cleaning. There is not statement of skilled medical need (such as need for intravenous medication). In the absence of such documentation, the currently requested home health care is not medically necessary.

Motorized wheelchair qty: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain section, power mobility devices.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

Decision rationale: Regarding the request for an electric scooter, the Chronic Pain Medical Treatment Guidelines state that powered mobility devices are not recommended if the functional 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. Within the documentation available for review, the notes indicate associated with this request (including notes dated 4/20/15 & 7/29/15) fail to provide a comprehensive neurologic assessment, including motor testing of upper extremity strength. While there is documentation of failure to use a walker, a powered wheelchair should only be granted if a manual wheelchair is not a suitable option. Without this comprehensive assessment, the current request is not medically necessary at this time.

Ongoing care for general orthopedic complaints qty: 1: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Office visits.

Decision rationale: Regarding the request for a follow-up visits in the future for ongoing orthopedic complaints, the California MTUS does not specifically address the issue. ODG cites that the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. Within the documentation available for review, there is clear documentation of continued pain, debility, and functional decline including a history of falls. The patient has ongoing musculoskeletal pain, and this current request is medically necessary.

Follow-up in 8 weeks qty: 1: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Office visits.

Decision rationale: Regarding the request for a follow-up visits in general, the California MTUS does not specifically address the issue. ODG cites that the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. Within the documentation available for review, there is documentation of continued pain, debility, and functional decline including a history of falls. The patient has ongoing musculoskeletal pain, and is taking pain medication including the controlled substance tramadol. Follow-up assessments are necessary, and this current request is medically necessary.

Lift chair qty: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Seat Lifts and Patient Lifts (Last Review: 9/20/11) Number: 04459 Policy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Durable medical equipment (DME).

Decision rationale: Regarding the request for lift chair, the California MTUS offers some guidelines regarding power mobility devices, but does not specifically mention the lift chair. ODG notes that medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury. A lift chair is a powered chair which positions the patient in an elevated and forward position for easier transfers. Within the documentation available for review, there is documentation that the patient states that has had some difficulty getting out of her chair at home. There does not appear to be a full physiotherapist assessment of this patient's ability to perform transfers in an objective manner. Often times patient with difficulty sit to stand transfers can have modification through training in PT/OT such that they can successfully perform a transfer in a different manner. In the absence of this documentation, the currently requested lift chair is not medically necessary.