

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]

Dated: 12/17/2013

| | |
|---------------------------|--------------|
| Employee: | [REDACTED] |
| Claim Number: | [REDACTED] |
| Date of UR Decision: | 7/17/2013 |
| Date of Injury: | 10/20/2009 |
| IMR Application Received: | 8/1/2013 |
| MAXIMUS Case Number: | CM13-0005933 |

DEAR [REDACTED],

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, has a subspecialty in Fellowship Trained in Cardiovascular Disease and is licensed to practice in Texas. 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 44-year-old male who reported an injury on 10/20/2009. The most recent diagnoses include status post motor vehicle accident, head injury with loss of consciousness, headaches, depression with anxiety, right shoulder bursitis and tenosynovitis, right shoulder impingement syndrome, right wrist carpal instability, status post proximal row fusion with internal fixation, left forearm wrist laceration, lumbar spine sprain/strain, left lower mangled extremity, status post multiple irrigations and debridements and above-the-knee amputation, status post split thickness skin graft from right thigh to cover left thigh wounds, status post closure of left thigh skin graft wound, right plantar fasciitis and sexual dysfunction. The mechanism of injury involved a motor vehicle accident where the patient was thrown from the vehicle and sustained injuries to his head and left lower extremity. Subsequently, the patient's left lower extremity was amputated as a result of the injury. The patient was most recently evaluated by Dr. [REDACTED] on 06/19/2013. Objective findings included a mildly positive Hawkins testing on the right, decreased range of motion of the right shoulder, decreased flexion and extension of the right hand and wrist, decreased strength and tenderness to palpation over the plantar fascia of the right foot. The treatment plan included a new custom standard wheelchair, a motorized wheelchair backup, wheelchair cushions and caregiver assistance at least 12 hours per day for 7 days a week. Also requested for authorization was a 1 year gym membership.

IMR DECISION(S) AND RATIONALE(S)

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

- 1. Custom standard wheel chair is medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines, Foot & Ankle Chapter, Low Back, Knee and Leg Chapter, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Knee Chapter, Online Edition, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The Official Disability Guidelines state that a manual wheelchair is recommended if the employee requires and will use a wheelchair to move around in their residence and is prescribed by a physician. Adjustable height armrest option is recommended if the employee has a need for an arm height different from that available using nonadjustable arms. Elevating leg rest option is recommended if the employee has a cast, brace or musculoskeletal condition which prevents 90 degree flexion. A reclining back option is recommended if the employee has a trunk cast or brace and requires the need to rest in a recumbent position 2 or more times during the day. The employee does currently meet criteria for a manual wheelchair as outlined by the above-mentioned guidelines. Given the exceptional factors noted on 06/19/2013, the request for a custom fit wheelchair is medically appropriate for this employee. **The request for a custom standard wheel chair is medically necessary and appropriate.**

2. Error! Reference source not found. is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page 51, which is part of the MTUS..

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 51, which is part of the MTUS..

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines state that home health services are recommended only for medical treatment for employees who are homebound on a part-time or intermittent basis, generally up to no more than 35 hours per week. 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. The current request exceeds guideline recommendations of no more than 35 hours per week. The clinical notes submitted indicate that the employee does have assistance from a spouse around-the-clock. The request for **Error! Reference source not found. is not medically necessary and appropriate.**

3) Error! Reference source not found. is not medically necessary and appropriate .

The Claims Administrator based its decision on the Official Disability Guidelines (ODG). Gym Memberships, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Knee Chapter, Online Edition, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The Official Disability Guidelines state that gym memberships are not recommended as a medical prescription unless a home exercise program has not been effective, and there is a need for equipment. Plus, treatment needs to be monitored and administered by medical professionals. While an individual exercise program is of course recommended, more elaborate personal care where outcomes are not monitored by a health professional, such as gym memberships or advanced home exercise program, may not be covered under this guideline. The requesting provider has not outlined the goals for gym membership or frequency of gym attendance. In addition, the medical necessity of the membership was not addressed. **The request for a gym membership is not medically necessary and appropriate.**

4. Error! Reference source not found. is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pages 132, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 99, which is part of the MTUS

The Physician Reviewer's decision rationale:

The California MTUS Guidelines state that powered mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker or if the employee 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 injury recovery process; and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. The employee's spouse has been helping the employee with activities of daily living, and there is no mention of any other physical comorbidity or disability that would interfere with the employee being independent. It is unclear why the employee requires a powered mobility device. **The request for a motorized back up wheel chair is not medically necessary and appropriate.**

5. Wheel chair cushions is medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Foot & Ankle Chapter, Low Back, Knee and Leg Chapter, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Knee Chapter, Online Edition, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The Official Disability Guidelines state that manual wheelchairs are recommended if the employee requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician. The documentation indicates that the employee has undergone an above-the-knee amputation and currently utilizes a prosthetic leg. The most recent progress note on 06/19/2013 indicated that the employee's current wheelchair was not large enough to accommodate the employee while wearing the prosthetic leg. While the custom wheelchair was determined as medically necessary, the associated request for wheelchair cushions is also found medically necessary. **The request for wheel chair cushions is medically necessary and appropriate.**

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

