

Case Number:	CM13-0038405		
Date Assigned:	12/18/2013	Date of Injury:	08/14/2002
Decision Date:	03/05/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/25/2013

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 Anesthesiology has a subspecialty in Pain Management and is licensed to practice in Georgia. 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. 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 presented with neck, upper back, bilateral shoulders, mid and lower back, right buttock, bilateral wrists, bilateral hands, bilateral knees and bilateral leg pain following a work related injury on 8/14/2002. The pain is associated with right knee swelling, headaches. The pain is described as burning, aching and piercing pain. The claimant is status post bilateral knee arthroscopy and two debridements following an infection. The physical exam was significant for decreased range of motion of the lumbar spine, + sitting straight leg raise, gross massive edema right greater than left, open wound on the right leg. MRI of the right knee was significant for right lateral meniscus tear. MRI of the lumbar spine was significant for L4-5 degenerative disc disease and protrusion. EMG was significant for bilateral S1 radiculopathy. The claimant was diagnosed with right shoulder pain, right hip pain secondary to contusion and strain status post fall, chronic bilateral lower extremity lymphedema, right knee lateral meniscus tear, lumbar spine sprain/strain with L4-5 degenerative disc disease, radiculopathy. The claimant has tried acupuncture, aqua therapy and weight loss program. The medical records on 4/3/2012 notes that the claimant had a home wound care nurse for approximately 5 months. The claimant's medications include oxycontin, trazodone, Soma and ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued home health care assistance 6 hrs/day x 7 days per week: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health services Page(s): 51.

Decision rationale: Continued Home Health Care assistance 6 hrs/day x 7 days per week is not medically necessary. Per CA MTUS page 51 Home health services are "Recommended only for otherwise recommended medical treatment for patients 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 patient was diagnosed with right shoulder pain, right hip pain secondary to contusion and strain status post fall, chronic bilateral lower extremity lymphedema, right knee lateral meniscus tear, lumbar spine sprain/strain with L4-5 degenerative disc disease, radiculopathy. The patient does not have a medical condition that denotes he is homebound on a part-time or full time basis.

Motorized scooter: Upheld

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

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

Decision rationale: A motorized scooter is not medically necessary. Per MTUS guidelines page power mobility devices such as a motorized scooter is "not recommended if the functional mobility 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. 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." There is lack of documentation in the medical records that the patient does not have sufficient upper extremity strength either to use a cane, walker or manual wheelchair.

Hospital bed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clinical Policy Bulletins, Number 0543, Hospital Beds and Accessories Policy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare guidelines 2013 Criteria for coverage of hospital beds. (Medicare.com).

Decision rationale: A hospital bed is not medically necessary. The Ca MTUS and ODG do not present a specific statement. The evidence for my rationale is provided by the Medicare criteria for hospital beds. Per Medicare criteria to qualify for a hospital bed the patient must show a 1) change in position not possible on a normal bed; 2) Lay or sleep in positions not possible with a normal bed in order to relieve pain; 3) has to sleep with the head of the bed higher than 30° because of conditions such as congestive heart failure, breathing problems, or other types of problems; 4) use traction equipment that must be attached to a hospital bed; 5) Heather certificate of medical necessity that is completed, signed and dated by the treating doctor. The medical records lack documentation of a medical necessity for a hospital bed as listed by Medicare criteria or other similar guidelines.