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| <b>Case Number:</b>   | CM14-0007608 |                              |            |
| <b>Date Assigned:</b> | 02/10/2014   | <b>Date of Injury:</b>       | 07/01/1992 |
| <b>Decision Date:</b> | 06/24/2014   | <b>UR Denial Date:</b>       | 01/15/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/21/2014 |

### 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 Anesthesiology, has a subspecialty in Pain Medicine 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 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 50-year-old female who sustained an injury to her low back on July 01, 1992. The records indicate the injured worker continues to complain of low back pain that radiates into the left lower extremity with numbness and tingling in the left leg. Physical examination dated December 30, 2013 was unremarkable. The records indicate the injured worker has been receiving home healthcare services four days per week and home health assistance to suggest new modifications made to activities of daily living. The request for occupational home therapy evaluation was made and a wheelchair is being requested in order to enable the injured worker to perform essential activities of daily living.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**WHEELCHAIR-PORTABLE WITH REMOVABLE WHEELS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online version, durable medical equipment

**Decision rationale:** The request for portable wheelchair with removable wheels is not medically necessary. The previous request was denied on the basis there was no clear documentation of the condition/diagnosis with subjective/objective findings for a specialized wheelchair to be medically necessary and/or the injured worker requires a wheelchair to move around in the residence. There was no additional significant objective information that would indicate medical necessity for a specialized wheelchair with removable wheels compared to a traditional wheelchair. Given the clinical documentation submitted for review, medical necessity of the request for portable wheelchair with removable wheels has not been established.

**OCCUPATIONAL THERAPY HOME EVALUATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

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

**Decision rationale:** The request for occupational therapy home evaluation is not medically necessary. The previous request was denied on the basis that there was no documentation the injured worker requires recommended medical treatment and is homebound on a part-time or intermittent basis. There were no other comorbidities identified that would require the requested occupational therapy home evaluation. Given the clinical documentation submitted for review, medical necessity of the request for occupational therapy home evaluation has not been established.

**HOME ASSISTANCE AID (4 DAYS A WEEK/ 4 HOURS A DAY):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

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

**Decision rationale:** The request for home assistance aid (four days a week, four hours a day) is not necessary. There California Medical Treatment Utilization Schedule (CAMTUS) states, 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. Given the clinical documentation submitted for review, medical necessity of the request for home assistance aid (four days a week, four hours a day) has not been established.