

Case Number:	CM14-0007797		
Date Assigned:	02/07/2014	Date of Injury:	11/22/2011
Decision Date:	06/30/2014	UR Denial Date:	01/08/2014
Priority:	Standard	Application Received:	01/17/2014

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 Occupational Medicine, and is licensed to practice in California. 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 patient is a 37 year-old male who has filed a claim for ankle enthesopathy associated with an industrial injury date of November 22, 2011. Review of progress notes reports that this patient is status post right ankle ATFL repair and peroneal retinaculum repair on January 06, 2014. Patient reports well-controlled pain of the right ankle. MRI of the right ankle dated October 30, 2013 showed an intraarticular body along the dorsal talar neck, tendinosis of the peroneus longus, and a split tear of the peroneus longus. Of note, the patient also has right hip and low back pain, with radiation down the right leg. Treatment to date has included NSAID, opioids, physical therapy, hip and back injections, use of a boot, and right ankle surgery. Utilization review from January 08, 2014 denied the request for lawn care as there is no support for non-medical home services, and lift chair as medical necessity is not established.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF LAWN CARE, NO FREQUENCY/DURATION INDICATED: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 51. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: CA Labor Code 4600(a).

Decision rationale: As noted on page 51 of the CA MTUS Chronic Pain Medical Treatment Guidelines, 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, which does not include homemaker services. In this case, there is no documentation that this patient is home bound, and services are only recommended for medical treatment related services. It is unclear why lawn care would be considered medical treatment. This is not a medical service for the cure or relief of an industrial injury, and is therefore not within the scope of utilization review as described within LC4610 and 8CCR9792 et seq. Because this service is not within the scope of utilization review, and because 8CCR9792.6 defines authorization as an assurance of reimbursement, this item must be non-certified. This outcome is purely procedural, and is not intended and should not be interpreted as a valid opinion regarding whether this service is or is not necessary; and is or is not compensable. These questions are outside the scope of utilization review for medical necessity, and are properly left to the claims administrator. Therefore, the request for purchase of lawn care was not medically necessary.

PURCHASE OF A LIFT CHAIR: Upheld

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) Knee and Leg chapter, Wheelchair

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. ODG recommends use of a manual wheelchair if the patient requires one to move around in the residence. Reclining back option is recommended if the patient has a trunk cast or brace, excessive extensor tone of the trunk muscles, or a need to rest in a recumbent position two or more times during the day. Elevating legrest option is recommended if the patient has a cast, brace or musculoskeletal condition, which prevents 90-degree flexion of the knee, or has significant edema of the lower extremities. Adjustable height armrest option is recommended if the patient has a need for arm height different than that available using non-adjustable arms. A lightweight wheelchair is recommended if the patient cannot adequately self-propel (without being pushed) in a standard weight manual wheelchair. In this case, the patient is status post right knee surgery. There is no indication that this patient has problems with mobility. There are no findings to support the use of a specialized chair in the patient. Therefore, the request for purchase of a lift chair was not medically necessary.