MAXIMUS Federal Services

Case Number:	CM14-0011210		
Date Assigned:	02/21/2014	Date of Injury:	06/06/1991
Decision Date:	06/25/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	01/28/2014

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 79-year-old, who has submitted a claim for Pelvic Fracture OT, closed associated with an industrial injury date of June 6, 1991. Medical records from 2013, were reviewed which showed that that the patient complained of bilateral knee pain, with significant difficulty with weight bearing. On physical examination of the cervical spine, mild paraspinal tenderness was noted. Spurling's sign was negative. Examination of the thoracolumbar spine showed paraspinal and vertebral tenderness. Examination of the right lower extremities showed soft tissue swelling and edema. Valgus and lateral joint tenderness were noted on the right knee, with pain on patellar ballottement. Examination of the left lower extremities showed soft tissue swelling at the knee, as well as grade 2 pitting edema. Valgus and lateral joint line tenderness were noted on the left knee, with pain on patellar ballottement. Range of motion (ROM) of the left knee was between 5-10 degrees. Treatment to date has included the use of a walker. Utilization review from January 23, 2014, denied the request for continued home care for eight (8) hours a day because, records reviewed did not document an evidence of homebound status. The decision for motorized wheelchair/scooter was also denied because, there was no documentation why she was unable to to use a non-motorized wheelchair.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTINUED HOME CARE FOR EIGHT (8) HOURS A DAY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES., CHAPTER: HOME HEALTH SERVICES , 51

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 51.

Decision rationale: According to the 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. 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. In this case, the patient was prescribed home care due to the elderly condition of the patient. However, based on the records reviewed, there was no documentation that the patient was homebound. Furthermore, there is no discussion concerning the type of professional nursing services needed by the patient in the form of health care. In addition, the request for continued home care for 8 hours a day exceeds the guideline recommendation of not more than 35 hours per week. The request for continued home care for eight hours a day is not medically necessary or appropriate.

MOTORIZED WHEELCHAIR/SCOOTER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES., CHAPTER: POWER MOBILITY DEVICES (PMDS) , 99

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 132.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, power mobility devices are 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. In this case, the reason for prescribing motorized wheelchair / scooter was due to the worsening physical abilities in the knees. However, there's no documentation that a walker cannot support the patient during ambulation, nor that the patient has an upper extremity disability, that restrain her from using a manual wheelchair. The request for a motorized wheelchair/scooter is not medically necessary or appropriate.