

<b>Case Number:</b>	CM14-0018119		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	07/24/2012
<b>Decision Date:</b>	06/26/2014	<b>UR Denial Date:</b>	02/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, 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 59-year-old female with a date of injury of 07/24/2012. The earliest report provided for review by the requesting physician, [REDACTED], is from 07/28/2012. This report indicates the patient has pain with range of motion in his knees. He has diffused joint line tenderness and swelling. The patient was diagnosed with right knee posttraumatic arthritis and status post scope x2. The treatment plan included follow-up with the orthopedic surgeon and consider total knee replacement. The most recent progress report provided for review is from 02/07/2014 by a [REDACTED] indicates the patient has medial and lateral knee pain along with swelling. Examination of the right knee shows a +1 effusion and range of motion from 0 to 120 degrees. The patient is exquisitely tender over the lateral joint line, moderately tender over the medial joint line and has some subtle plus one anterior instability with some subtle plus one valgus instability. It was noted that the MRI (magnetic resonance imaging) "now shows an anterior cruciate ligament (ACL) tear." The treating provider states it does not appear to be an obvious lateral meniscal tear but a recurrent tearing of the medial meniscus along with some degenerative changes. The request is for an adjustable bed, home ergonomic evaluation, mobility evaluation, light weight wheelchair, motorized wheelchair, and electric scooter with lift appliance. Utilization review denied the request on 02/11/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ADJUSTABLE BED:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [http://www.bcbsnc.com/services/medical-policy/pdf/durable\\_medical\\_equipment\\_\(dme\).pdf](http://www.bcbsnc.com/services/medical-policy/pdf/durable_medical_equipment_(dme).pdf), Official Disability Guidelines (ODG), Low back, Mattress selection, and AETNA clinical policy bulletin: Hospital beds and accessories.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back [http://www.odg-twc.com/odgtwc/low\\_back.htm#Protocols](http://www.odg-twc.com/odgtwc/low_back.htm#Protocols)

**Decision rationale:** This patient presents with chronic knee pain. The patient sustained a knee injury when she fell off a ladder in 07/24/2012. The patient was treated conservatively and ultimately underwent knee surgery in 02/04/2013. Postoperatively, it was noted she improved slightly for about 4 weeks and then had significant increase in pain. The request is for an adjustable bed by [REDACTED]. The only progress report provided for review by [REDACTED] in the medical file is dated 07/28/2012. The MTUS and ACOEM guidelines do not discuss adjustable beds. However, Official Disability Guidelines (ODG) does quote one study and indicates that this is under study: "Under study. A recent clinical trial concluded that patients with medium-firm mattresses had better outcomes than patients with firm mattresses for pain in bed, pain on rising, and disability. A mattress of medium firmness improves pain and disability among patients with chronic non-specific low-back pain." Furthermore, the ODG discusses durable medical equipment and states that for an equipment to be considered medical treatment, it needs to be used primarily and customarily for medical purpose; generally is not useful to a person in the absence of illness or injury. In this case, a bed does not meet these criteria. The recommendation is for denial.

#### **HOME ERGONOMIC EVALUATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand Chapter, Ergonomic interventions

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 262.

**Decision rationale:** This patient presents with chronic knee pain. The patient sustained a knee injury when she fell off a ladder in 07/24/2012. The patient was treated conservatively and ultimately underwent knee surgery in 02/04/2013. Postoperatively, it was noted she improved slightly for about 4 weeks and then had significant increase in pain. The request is for a "home ergonomic evaluation" by [REDACTED]. The only progress report provided for review by [REDACTED] in the medical file is dated 07/28/2012. For Ergonomic evaluation, the ACOEM guidelines states, "The clinician may recommend work and activity modifications or ergonomic redesign of the workplace to facilitate recovery and prevent recurrence." In this case, the ACOEM guidelines support ergonomic evaluations for the work place to accommodate through ergonomic changes to hasten the employee's return to full activity. The treating provider does

not indicate that the patient is to be working from home. The requested Home ergonomic evaluation is not recommended.

**MOBILITY EVALUATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8.

**Decision rationale:** This patient presents with chronic knee pain. The treating provider is requesting a mobility evaluation. The MTUS indicate that "The physician should periodically review the course of treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of pain management depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities." In this case, it is unclear as to what exactly a mobility evaluation would entail and why it would not be part of a general evaluation during a regular check up. As such, the recommendation is for denial.

**LIGHTWEIGHT WHEELCHAIR:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AETNA Clinical policy bulletin: Wheelchairs and power operated vehicles (scooters), [http://www.aetna.com/cph/medical/data/200\\_299/0271.html](http://www.aetna.com/cph/medical/data/200_299/0271.html).

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

**Decision rationale:** This patient presents with chronic knee pain. The treating provider is requesting a light weight wheelchair. A utilization review 02/11/2014 denied the request stating, "This patient has osteoarthritis. She is able to stand and walk independently." The ACOEM and MTUS guidelines do not discuss wheelchairs. The Official Disability Guidelines (ODG) states, "Recommend manual wheelchair if the patient requires and will use a wheelchair to move around in their residence, and it is prescribed by a physician." In this case, the examination on 02/07/2014 indicates the patient has swelling and some subtle instability. The treating provider is requesting a wheelchair which is in accordance with ODG guidelines. Thus, the recommendation is for approval.

**MOTORIZED WHEELCHAIR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines POWER MOBILITY DEVICES, . Decision based on Non-MTUS Citation Official Disability

Guidelines (ODG), Pain, Power Mobility Devices, and AETNA Clinical policy bulletin: Wheelchairs and power operated vehicles (scooters), [http://www.aetna.comcph/medical/data/200\\_299/0271.html](http://www.aetna.comcph/medical/data/200_299/0271.html).

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

**Decision rationale:** This patient presents with chronic knee pain. The treating provider is requesting a motorized wheelchair. For power mobility devices, the MTUS Guidelines states "not recommended if the functional mobility deficits 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 assistant with the manual wheelchair. Early exercise mobilization and independence should be encouraged at all steps of injury recovery process, and if there is any mobility with canes or other devices, a motorized scooter is not essential to care." In this case, physical examination does not reveal the patient being unable to use a cane or walker, or that the patient has upper extremity strength issues to not be able to handle a manual wheelchair. Thus, the recommendation is for denial.

**ELECTRIC SCOOTER WITH LIFT APPLIANCE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Power Mobility Devices, and AETNA Clinical policy bulletin: Wheelchairs and power operated vehicles (scooters), [http://www.aetna.comcph/medical/data/200\\_299/0271.html](http://www.aetna.comcph/medical/data/200_299/0271.html).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99. Decision based on Non-MTUS Citation AETNA guidelines

**Decision rationale:** This patient presents with chronic knee pain. The treating provider is requesting an electric scooter with lift appliance. The medical file provided for review indicates the patient underwent a right knee arthroscopy in February 2012. Power Mobility Devices under MTUS states, "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." The ACOEM, MTUS and ODG Guidelines do not discuss chair lifts. The AETNA guidelines support chair or patient lifts if the patient is incapable of standing from a seated position, among other requirement. There is no evidence that this patient is unable get up from a seated position. In this case, physical examination does not reveal the patient being unable to use a cane or walker, or that the patient has upper extremity strength issues to not be able to handle a manual wheelchair. Thus, the recommendation is for denial.