

<b>Case Number:</b>	CM14-0150814		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	09/08/2006
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2014

### 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 Orthopedic Spine Surgeon, 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 reported an injury on 09/11/2006. The mechanism of injury was not provided. She is diagnosed with status post cervical spine fusion at C4 to C7. Her past treatments included medications, physical therapy, and epidural steroid injections. On 11/04/2014, the injured worker reported worsening low back pain. Upon physical examination of her lumbar spine, she was noted to have spasm and painful limited range of motion. His current medications were not provided. Treatment plan included medications, followup appointment in 4 to 6 weeks, and a request for additional physical therapy. The request was received for front wheel walker, three in one commode, and home health nurse, four (4) times a day, five (5) days a week for two (2) months (post op wound evaluation and home health care); however, the rationale was not provided. A Request for Authorization was submitted on 09/04/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Front wheel walker:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Procedure summary last updated 01/09/2013 - walking aids.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Durable Medical Equipment (DME)

**Decision rationale:** The request for front wheel walker is medically necessary. Injured worker is diagnosed with status post cervical spine fusion C4-7. The Official Disability Guidelines recommend a walking aid to assist with safe ambulation and to prevent re-injury during postsurgical phase of recovery. In the above information, the request is supported by the guidelines. As such, the request is medically necessary.

**Three in one commode.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Procedure summary last updated 01/09/2013- DME

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Durable Medical Equipment (DME)

**Decision rationale:** The request for three in one commode is not medically necessary. The Official Disability Guidelines state that bathroom related durable medical equipment is only indicated for patients who are confined to a single room in their home. The clinical documentation provided lacks evidence that the injured worker is confined to 1 room within her home. Therefore, the request is not supported by the guidelines. As such, the request is not medically necessary.

**Home health nurse, four times a day, five days a week for two months (post op wound evaluation and home health care):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services.

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

**Decision rationale:** The request for home health nurse, four times a day, five days a week for two months (post op wound evaluation and home health care) is not medically necessary. The California MTUS Guidelines recommend home health services for patients who are home-bound, on a part time or intermittent basis. The guidelines recommend generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, laundry and personal care given by home health aides like bathing, dressing, and using the bathroom when there is only care needed. The clinical documentation does not indicate that the injured worker is home-bound, on part time or intermittent basis. There is no documentation indicating the injured worker has any functional deficits or evidence of significantly limited

mobility. Given the above information, the request is not supported by the guidelines. As such, the request is not medically necessary.