

Case Number:	CM14-0032163		
Date Assigned:	06/20/2014	Date of Injury:	10/18/2012
Decision Date:	07/21/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	03/11/2014

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 California & Nevada. 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 54 year old female who presented with injuries to both knees. The clinical note dated 09/11/13 indicates the injured worker continuing with pain and mechanical symptoms at the right knee. There is an indication the injured worker has previously undergone a lengthy course of conservative care. The injured worker also reported low back and wrist pain. The magnetic resonance imaging of the lumbar spine dated 01/27/14 revealed disc desiccation at L3-4 through L5-S1. A broad based disc protrusion indenting the thecal sac was identified at L3-4. A disc protrusion indenting the thecal sac was also identified at L4-5 and L5-S1. The clinical note dated 03/26/14 indicates the injured worker complaining of swelling and edema at the lateral aspect of the right ankle. The injured worker also reported ongoing pain at the lateral collateral ligament. Psychiatric consultation report dated 05/21/14 indicates the injured worker complaining of an increase in anxiety and depression. The clinical note dated 05/28/14 indicates the injured worker complaining of bilateral shoulder and wrist pain. The injured worker also had complaints of bilateral knee pain rated as 5/10. The utilization review dated 03/11/14 resulted in a denial for a motorized wheelchair, home health assessment and the use of a Norco soft device as insufficient information had been submitted regarding the injured worker's inability to utilize a manual wheelchair or the need for an adaptive device of the upper extremity. Additionally, no information had been submitted confirming the need for home health care.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: Motorized wheelchair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices ((PMDs).

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, Power mobility devices (PMDs).

Decision rationale: The documentation indicates the injured worker complaining of pain at several areas. A motorized wheelchair is indicated for injured workers who are unable to ambulate for any length of distance and have demonstrated significant upper extremity deficits. No information was submitted regarding the injured worker's strength deficits in the upper extremities. Therefore, the request for DME: motorized wheelchair is not medically necessary.

Home Health to evaluate shower and bathing area: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AETNA Clinical Policy Bulleting Home Health Aides, May 17,2005, ODG -Official Disability Guidelines.

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

Decision rationale: Home health services are indicated for injured workers who are home bound and require intermittent or part time medical care. Home health services to include showering and bathing are not included in medical services. Therefore, the request for home health to evaluate shower and bathing area is not medically necessary.

Norco Soft (MP Ulnar Drift Support): 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, Durable Medical Equipment.

Decision rationale: No information was submitted regarding the injured worker's upper extremity deficits to include the need for an ulnar drift support device. Therefore, the request for Norco Soft (MP Ulnar Drift Support) is not medically necessary.