

<b>Case Number:</b>	CM14-0046319		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	04/15/1998
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	04/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 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 injured worker is a 48-year-old female who reported a fall from a chair on 04/15/1998. On 06/02/2014, her diagnoses included right cubital tunnel syndrome, right C5 radiculopathy confirmed by EMG, pseudoarthrosis posteriorly at L4-S1, degenerative disc disease L4-S1, bilateral lumbar radiculopathy, status post lumbar fusion and bilateral sacroiliac joint dysfunction. She had multiple back surgeries, arm surgeries, elbow surgeries, and knee surgeries. She has a history of multiple falls. Medications include Norco 10/325 mg, oxycodone 30 mg, Oxycontin 80 mg, Prozac 20 mg, tizanidine 6 mg, Compazine 10 mg, Lasix 40 mg, Lidoderm patch 5%, Lomotil tablets 2.5-0.025 mg, Lyrica 50 mg, Marinol 10 mg, Restoril 30 mg, Xanax 2 mg, and a topical compounded cream. Her upper and lower extremities ranges of motion were all basically within normal limits. It is noted that she walks with a normal gait and has a normal heel-toe swing-through gait with no evidence of limp. There was no evidence of weakness walking on the toes or the heels. There was no gross deformity of the lumbar spine or lower extremities with no appreciable swelling or gross atrophy of the paravertebral muscles. There was no evidence of scoliosis with a normal lordosis. On examination there was no tenderness upon palpation of the sacroiliac joint or the coccyx. There were no abnormalities in the examination of the cervical spine. Rationale for the motorized scooter stated that this worker has segmental kyphosis with a forward flexed gait which will not improve without corrective surgery. In an attempt to avoid surgery, this scooter was requested. It was further noted that she has been taking an extremely high dose of narcotics for the past 10 years. The request for authorization dated 06/02/2014 was included with the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home Health Aide services for 3 months:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines HOME HEALTH SERVICES Page(s): 51.

**Decision rationale:** The request for home health aid services for 3 months is not medically necessary. California MTUS guidelines recommend home health services only for patients who are homebound, on a part-time or intermittent basis, and 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 aids like bathing, dressing, and using the bathroom when this is the only care that is needed. This worker is ambulatory and is able to get to appointments. There was no documentation that she was homebound. There was no documentation regarding functional deficits that would require a home health aid. Additionally, the request did not specify the number of hours in a day or in a week that the home health aid's assistance would have been required. Therefore, the request for home health aid services for 3 months is not medically necessary.

**Scooter:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 99.

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

**Decision rationale:** The request for a scooter is not medically necessary. California MTUS guidelines do not recommend power mobility devices 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 stages 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. This worker's lower extremity ranges of motions and strength are all within normal limits. She is able to ambulate independently. Additionally, there is no evidence of a home study having been performed to determine whether or not the scooter would be functional in her home environment. Therefore, this request for scooter is not medically necessary.