

Case Number:	CM15-0004933		
Date Assigned:	01/16/2015	Date of Injury:	01/10/2012
Decision Date:	03/11/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	01/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Arizona, California

Certification(s)/Specialty: Family Practice

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 52 year old male patient, who sustained an industrial injury on 01/10/2012. He was diagnosed with CRPS, peripiheral neuropathy froma crush injury , depression, insomnia, PTSD and a failed malleolar fracture. A primary treating office visit (Orthopedic/Spine) dated 10/28/2014 reported a chief complaint of continuation of multiple orthopedic complaints related to bilateral lower extremities. The patient notes continued pain in the left foot. He is still using the cam walker and wheelchair constantly. He has a history for multiple falls secondary to weakness. He is diagnosed with status post trauma; probalbe nonunion medial malleolar fracture, status post incise and drainage, left sided foot drop, and intractable low back pain. The plan of care involve continuing with acupunture and psychiatric treatment. In addition, an internal medicine request was made for blood pressure management but no vitals were noted at the Octoiber 2014 visit. A request was made for a motorized wheelchair since the claimant has shortness of breath with a manula wheelchair. Home health was requested due to multiple falls. He is prescribed the following medications; Norco 10/325 MG, Anaprox DS, Prilosec, Synovacin, Colace, Xanax, Neurotin, Restiril and Melatonin. A pain management follow up visit dated 11/19/2014 described since the last visit he has had no treatment other than medication and acupunture with peripheral nerve stimulation; last visit noted one week prior. Blodd pressure at the time was 122/84 and the claimant was on Benzapril, Clonidine and Carvedilol. Per the patient he has failed to respond to physical therapy with note of the only relief so far has been with acupunture/nerve stimulation. On 12/09/2014 Utilization Review non-certified reequest for home health evaluation, a follow up with internal medicine and

a motorized wheel chair, noting the CA MTUS Home Health and Official Disability /Guidelines Orthosis were cited. The injured worker submitted an application for independent review of requested services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Internal medicine referral: Overturned

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 Office visits and pain

Decision rationale: According to the guidelines, office visits are recommended as medically necessary. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In this case the blood pressure was normal but had had been on multiple (3) medications for hypertension management. Prior blood pressure elevation was noted to be due to pain rather than primary hypertension. The request for an internal medicine consult is appropriate based on multiple medication use and need for routine cardiac exams and blood/urine workup for managing medications related to hypertension.

Home health evaluation: 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 Page(s): 51.

Decision rationale: 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 request for home health due to falls did not specify length of need for such assistance. The cause of falls were not specified and how home health may prevent this when they are not available. As a result, the request is not medically necessary as requested.

Motorized wheelchair: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Power mobility devices.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation Knee pain and powered mobility devices

Decision rationale: According to the guidelines, motorized wheel chair 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, there is mention of shortness of breath with use of a manual wheelchair, but distance or amount of use with precipitation of dyspnea is not mentioned. A lung or pulmonary exam is not noted. The claimant is not known to have pulmonary disease or heart failure. There is no mention of upper extremity weakness. There is also mention that a wheelchair cannot be used in most places due to access issues. The motorized wheel chair is not medically necessary due to lack of supporting clinical information to justify inability to use a manual wheelchair.