

<b>Case Number:</b>	CM15-0133335		
<b>Date Assigned:</b>	07/21/2015	<b>Date of Injury:</b>	06/06/2001
<b>Decision Date:</b>	08/18/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2015

### 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: New Jersey, Alabama, California

Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 64 year old female, who sustained an industrial injury on 06-06-2001 secondary to continuous trauma. On provider visit dated 05-20-2015 the injured worker has reported presurgical and postsurgical neurologic injuries to the nerves to both upper extremities with partial paralysis of both upper extremities including the shoulder and arms. The injured worker was noted to have upper spinal cord syndrome with upper extremity weakness and some lower extremity weakness and instability when being. She was noted to need assistance with activities of daily living on an ongoing basis and she is unable to use rollator or manual wheelchair due to neurologic weakness. The diagnoses have included status post cervical spine surgery 03-20-2003, chronic bilateral cervical myelopathy with noted classic syndrome of upper extremity weakness more than lower extremity becoming progressively worse and chronic strain-sprain of the lumbosacral spine and associated musculoligamentous structures with abnormal f wave indication lumbar radiculopathy and urge incontinence-irritable bladder syndrome probably secondary to neurologic spinal cord injury. The provider requested wheelchair-electric and home health care assistance +2 hours/day for 9 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Wheelchair electric:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Power mobility devices. <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, Power mobility devices "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. (CMS, 2006) 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." There is no clear evidence that the patient's mobility deficit cannot be controlled with a cane or walker and there is no clear need for an electrical chair. Therefore, the request for electric wheelchair is not medically necessary.

**Home health care assistance +2 hours/day for 9 months: Upheld**

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

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

**Decision rationale:** According to MTUS guidelines, home care assistance is "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. (CMS, 2004)." The patient does not fulfill the requirements mentioned above. There is no documentation that the patient's recommended medical treatment requires home health aide. In addition, there is no documentation that the patient was homebound or need assistance with ADLs. Therefore, the request for Home health care assistance +2 hours/day for 9 months is not medically necessary.