

Case Number:	CM15-0187312		
Date Assigned:	09/29/2015	Date of Injury:	03/11/2005
Decision Date:	11/06/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/23/2015

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: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports 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 46 year old male, who sustained an industrial injury on 3-11-2005. The medical records indicate that the injured worker is undergoing treatment for status post L5-S1 fusion (1-13-2010) with significant post-operative pain as well as persistent left lumbar radiculopathy, coccygeal strain, and spasticity and hyperreflexia of the upper and lower extremities. According to the progress report dated 7-31-2015, the injured worker presented with complaints of low back pain with radiation into the lower extremities. On a subjective pain scale, he rates his pain 8 out of 10. The physical examination of the lumbar spine reveals restricted range of motion, positive straight leg raise test bilaterally, and positive Lasegue's test on the left. Per the neurological exam, the injured worker walked with a slow, forward-flexed gait. He is noted to have moderate antalgia using a two-wheeled walker. Without leaning on the walker, his gait is significantly antalgic and slow. The treating physician notes that he continues to have great difficulty with activities of daily living on a daily basis. Previous diagnostic testing includes MRI studies. Treatments to date include medication management, physical therapy, intrathecal pump, spinal cord stimulator trial, and surgical intervention. Work status is described as permanently and totally disabled. The original utilization review (8-27-2015) had non-certified a request for home health care aide (4 hours a day - 7 days a week) and electric wheelchair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electric Wheelchair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs).

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Power Wheelchair. MTUS guidelines state the following: Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair. The clinical documents state that the patient had the upper extremity function intact to propel a manual wheelchair. According to the clinical documentation provided and current MTUS guidelines; a power Wheelchair is not indicated as a medical necessity to the patient at this time.

Home Health Care Aide for 4 Hours/Day for 7 Days A Week for Meal Prep/Housekeeping/Medication Reminders, ADL Assistance and transport to and from Medical Appointments x 12 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Home health care. MTUS guidelines state the following: Home health services; 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) According to the clinical documentation provided. The patient does not meet requirement for home health. Home Health-care is not indicated as a medical necessity to the patient at this time.