

Case Number:	CM15-0119568		
Date Assigned:	06/30/2015	Date of Injury:	03/31/2010
Decision Date:	09/22/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/22/2015

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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational 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 53 year old male, who sustained an industrial injury on 3/31/10. He reported pain that traveled from his hands and wrists through his arms and toward his shoulders in both upper extremities. He also complained of pain in his lower back (both left and right). The injured worker was diagnosed as having a sprained lumbar region and joint pain in the hand. Treatment to date has included surgical intervention, psychological and medication. The injured worker complains of lower back pain, decreased sensation and numbness in his feet and toes. He is experiencing swelling and weakness of his lower extremities bilaterally. The injured worker is currently retired and not working. A note dated 2/27/12 states the injured worker was experiencing difficulties engaging in activities of daily living due to pain. He continued to experience tenderness in the lower back with limited and painful range of motion. There was also tenderness noted in his wrists and hands bilaterally with a slight loss of range of motion in his wrists. The injured worker is diagnosed with sleep apnea and uses a CPAP machine, but continues to report waking due to pain and anxiety. A note dated 3/6/15 indicates the injured worker carries a diagnosis of diabetes and experiences peripheral neuropathy. The injured worker is obese, has swelling in his lower legs, which requires wrapping and is therefore wheel chair bound, per note dated 4/20/15. The following requests are being made to continue to assist the injured worker; vehicular modification for motorized scooter, stair lift, therapy pool, home health services and convalescent facility.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vehicular Modification for Motorized scooter: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem Clinical UM Guidelines: Durable Medical Equipment, Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) http://www.dhcs.ca.gov/services/medi-cal/documents/mancriteria_32_medtrans.htm.

Decision rationale: The injured worker sustained a work related injury on 3/31/10. The medical records provided indicate the diagnosis of sleep apnea and uses a CPAP machine, but continues to report waking due to pain and anxiety. A note dated 3/6/15 indicates the injured worker carries a diagnosis of diabetes and experiences peripheral neuropathy. Treatments have included surgical intervention, psychological and medication. The medical records provided for review do not indicate a medical necessity for Vehicular Modification for Motorized scooter. Although the medical records indicate he needs a power mobility device like a motorized scooter, there was no guideline referencing the need for vehicular modification. Rather, a document in the California Department of Home Health Care Services entitled "CRITERIA FOR MEDICAL TRANSPORTATION AND RELATED SERVICES" (http://www.dhcs.ca.gov/services/medi-cal/documents/mancriteria_32_medtrans.htm) recommends that Wheelchair Van, may be indicated in cases of: 1. Beneficiary is wheelchair bound, and unable to self-transfer to a private or public conveyance, or cannot reasonably ambulate even with assistance or use of a walker or crutches so as to use a private or public conveyance, such as, but not limited to cases of: a. Bilateral amputee without prostheses. b. Severe paraplegic without bracing. c. General physical weakness and inability to ambulate without assistance due to old age. Therefore, though there was no document recommending for or against vehicular modification for scooter, the California Department of Home Health Care Services recommends that arrangement can be made for him to be transported with an appropriate van when needed for his medical services.

Stair lift, Qty 1: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem Clinical UM Guidelines: Durable Medical Equipment, Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Durable medical equipment (DME) and Other Medical Treatment Guidelines Medicare. <https://www.medicare.gov/coverage/durable-medical-equipment-coverage.html>.

Decision rationale: The injured worker sustained a work related injury on 3/31/10. The medical records provided indicate the diagnosis of sleep apnea and uses a CPAP machine, but continues to report waking due to pain and anxiety. A note dated 3/6/15 indicates the injured worker

carries a diagnosis of diabetes and experiences peripheral neuropathy. Treatments have included surgical intervention, psychological and medication. The medical records provided for review do indicate a medical necessity for: Stair lift, Qty 1. The medical records indicate the injured worker has limitations in the upper and lower limbs that make limits him from walking and using assistive manual assistive devices. The records indicate he needs to go up and down the stairs in his home; therefore, his doctor has recommended for stair lift. The request is medically necessary and appropriate and is covered by Medicare under Durable Medical Equipment. Medicare and the Official Disability Guidelines define Durable Medical Equipment as: Durable (long-lasting); Used for a medical reason; Not usually useful to someone who isn't sick or injured; Used in your home.

Therapy pool, indefinite use, Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg (Acute & Chronic) - Whirlpool bath equipment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

Decision rationale: The injured worker sustained a work related injury on 3/31/10. The medical records provided indicate the diagnosis of sleep apnea and uses a CPAP machine, but continues to report waking due to pain and anxiety. A note dated 3/6/15 indicates the injured worker carries a diagnosis of diabetes and experiences peripheral neuropathy. Treatments have included surgical intervention, psychological and medication. The medical records provided for review do not indicate a medical necessity for the requested treatment. The MTUS recommends Aquatic therapy (Pool therapy) as an optional form of exercise therapy, where available, as an alternative to landbased physical therapy. The MTUS states that Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The guidelines for aquatic therapy follows the physical Medicine guideline of allowing for a fading treatment for 8-10 sessions, then transitions to home exercises program. Therefore, although, this injured worker would benefit from aquatic therapy due to the mobility problems and morbid obesity, the requested treatment is not medically necessary due to the indefinite nature of the request.

Home health services, indefinite, Qty 1: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Home health services.

Decision rationale: The injured worker sustained a work related injury on 3/31/10. The medical records provided indicate the diagnosis of sleep apnea and uses a CPAP machine, but continues

to report waking due to pain and anxiety. A note dated 3/6/15 indicates the injured worker carries a diagnosis of diabetes and experiences peripheral neuropathy. Treatments have included surgical intervention, psychological and medication. The medical records provided for review do not indicate a medical necessity for Home health services, indefinite, Qty 1. The MTUS states that home health services 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. The pain chapter of the Official Disability Guidelines has provisions for additional services besides the services by a licensed healthcare personnel. However, this request is for an indefinite home health services. The Official Disability Guidelines states, "For Home Health Care extending beyond a period of 60 days, the physician's treatment plan should include referral for an in-home evaluation by a Home Health Care Agency Registered Nurse, Physical Therapist, Occupational Therapist, or other qualified professional certified by the Centers for Medicare and Medicaid in the assessment of activities of daily living to assess the appropriate scope, extent, and level of care for home health care services." The requested treatment is not medically necessary due to the indefinite nature of the request without an evaluation report from a licensed health professional.

Convalescent facility living, Qty 1: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Skilled nursing facility (SNF) care.

Decision rationale: The injured worker sustained a work related injury on 3/31/10. The medical records provided indicate the diagnosis of sleep apnea and uses a CPAP machine, but continues to report waking due to pain and anxiety. A note dated 3/6/15 indicates the injured worker carries a diagnosis of diabetes and experiences peripheral neuropathy. Treatments have included surgical intervention, psychological and medication. The medical records provided for review do not indicate a medical necessity for Convalescent facility living, Qty 1. This topic was not found in the MTUS, Official Disability Guidelines, Medscape, and the National Guidelines Clearinghouse. However, the Official Disability Guidelines mentioned a related entity, Skilled Nursing Care. This guideline states that Skilled Nursing Care is necessary after hospitalization when the patient requires skilled nursing or skilled rehabilitation services, or both, on a 24-hour basis. The recommended length of stay is 10-18 days. The medical records do not indicate the injured worker has just being released from the hospital. Also, the request did not specify the expected length of stay.