MAXIMUS Federal Services

Case Number:	CM15-0178531		
Date Assigned:	09/18/2015	Date of Injury:	06/13/2007
Decision Date:	11/02/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/10/2015

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: Texas, 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 51 year old female who sustained an industrial injury on 6-13-07. According to the medical records she has been treated for neck and back pain through the years. Treatments include: medication, physical therapy, epidural injections, intrathecal pain pump and surgery. Progress report dated 7-29-15 reports follow up of low and mid back pain. She was hospitalized the week prior for about 6 days due to complications from pneumonia. She has not started post op physical therapy yet. The injured worker states, she is slowly improving, her activity level is limited by pain and remains severe after surgery. She can only walk about a block while holding onto the back of her transport chair. The pain is rated 7-8 out of 10 and ranges from 7-10 out of 10. She is using the bone stimulator and continues to receive home health assistance due to recent cardiac complications and spinal conditions. She reports home assistance is absolutely necessary to help her get dressed, bathe, prepare food, do house work including vacuuming and cleaning and reminders for medications. Currently her mid back pain is described as constant, aching, burning, and stabbing pain. The pain radiates around the bilateral rib cage. The low back pain is described as constant, aching, burning, and stabbing with intermittent radiating pain into the left hip and left buttock similar to previous sciatica. Upon exam, she has tenderness on palpation over the bilateral greater trochanters and pain with hip range of motion. Diagnoses include: chronic pain syndrome, lumbar radiculopathy, pseudoarthrosis, adjacent segment disease, and left hip trochanteric bursitis. Plan of care includes: continue home health assistance due to continued severe pain to perform her activities of daily living safely and medications reminders, she is at risk for falling due to weakness in her

legs, request 7 days per week for 6 hours per day for an additional 3 months, request wheelchair model number [redacted], recommend proceed with bone density test, request pain management follow ups, continue with external bone stimulator, proceed with post operative physical therapy 2 times per week for 6 weeks. Work status: temporarily totally disabled while recovering from surgery. Follow up in 6 weeks. The medication list includes Dilaudid, Zofran, Oxycontin and Gabapentin. Per the note dated 8/5/15 the patient had complaints of low back pain, hand and wrist. Physical examination revealed tenderness on palpation over low back, 3/5 strength of lower extremity and 4/5 strength of upper extremity and full ROM of upper extremity and lower extremity, antalgic gait, negative SLR, positive Tinel sign over right wrist. Per the note dated 9/2/15 the patient had complaints of mid and low back pain at 7-8/10. Physical examination of the lumbar spine revealed limited range of motion and tenderness on palpation, 4/5 strength and severely antalgic gait. The patient was using an external bone stimulator for this injury. The patient had received home health assistance for this injury. The patient was hospitalized due to pneumonia on 7/21/15 for 5 days. Patient was seen in the ER on 8/4/15 due to bacterial pneumonia and she was admitted to the ICU for 3 days and then she was in the hospital for 3 more days. The patient had a history of falling. Per the note dated 9/3/15, the patient had a normal cardiovascular and respiratory tract examination. The details of any recent cardiac complications were not specified in the records specified. A residual effect of pneumonia on the cardiovascular system and respiratory system was not specified in the records specified. The current medication list does not contain medicines for any pathology related to the cardiovascular system. The patient had not received the post op physical therapy, which was authorized. The patient's surgical history included right thumb surgery on 7/6/15; 15 surgeries of bilateral wrist s, lumbar fusion in 2012.She is about 4 and a half months status post removal of hardware L1 and S1 on 3/19/15. The patient had received an unspecified number of the PT and acupuncture and aquatic visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health care 7 days a week for 6 hours a day times 3 months: 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: Per the CA MTUS guidelines cited below, regarding home health services "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 patient had received home health assistance for this injury. Continuation of home health services were requested 7 days a week for 6 hours a day times 3 months. The reasons for the request were stated as recent cardiac complications and spinal condition. The patient was hospitalized due to pneumonia on 7/21/15 for 5 days. Patient was seen in the ER on 8/4/15 due to bacterial pneumonia and she was admitted to the ICU for 3 days and then she was in the hospital for 3 more days. Per the note dated 9/3/15, the patient had a normal cardiovascular and respiratory tract examination. The details of any recent cardiac

complications were not specified in the records specified. A persistent residual effect of pneumonia on the cardiovascular system and respiratory system was not specified in the records specified. The current medication list does not contain medicines for any pathology related to the cardiovascular system. Documented evidence that the patient is totally homebound or bedridden is not specified in the records provided. The presence of conditions that would be expected to make the patient totally homebound or bedridden, for a continuous period of 3 months, was not specified in the records provided. A clear medical need for home health care services for all 7 days in a week for 6 hours a day for a continuous period of 3 months, is not specified in the records provided. Homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not considered medical treatment. Whether family members can do at least part of the homemaker service tasks, is not specified in the records provided. The patient had a history of falling. A detailed evaluation of the home environment to identify risk factors for falls and measures taken against such risk factors were not specified in the records provided. A detailed history of the circumstances around all the previous falls and how home health care for part of the day would prevent falls, in this patient, was not specified in the records provided. The request for Home health care 7 days a week for 6 hours a day times 3 months is not medically necessary in this patient.

Wheelchair purchase - model [redacted]: 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), Treatment Index, 13th Edition (web), 2015, Knee and Leg- wheelchair.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Power mobility devices (PMDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Integrated Treatment/Disability Duration Guidelines: Knee & Leg, Power mobility devices (PMDs) and Durable medical equipment (DME): Wheelchair.

Decision rationale: Per the CA MTUS chronic pain guidelines cited below, Power mobility 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." Per the ODG cited below, power mobility devices are not recommended "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." Per the note dated 8/5/15 the physical examination revealed full ROM of upper extremity and lower extremity, negative SLR. A detailed neurological exam demonstrating significant weakness of the upper and lower extremities or any other medical conditions that will compromise the patient's ability to ambulate by herself or with the help of a walker or cane, is not specified in the records provided. The absence of a caregiver who can propel a manual wheel chair was not specified in the records provided. An inability of the patient to ambulate with canes or other assistive devices was not specified in the records provided. The

detailed response to previous conservative therapy was not specified in the records provided. The medical necessity of the request for Wheelchair purchase - model [redacted] is not fully established in this patient.