

Case Number:	CM13-0015594		
Date Assigned:	10/09/2013	Date of Injury:	10/30/1998
Decision Date:	01/15/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 62-year-old female with a reported date of injury of 10/30/1998. Mechanism of injury is described as a slip and fall. CT myelogram performed on 12/17/2012 revealed (1) extensive thoracolumbar spinal fusion with a left L5 pedicle screw taking a medial course through the portion of the spinal canal extending throughout the left subarticular zone in the region of the left L5 nerve root; (2) there was also bilateral severe neural foraminal stenosis at L5-S1 with possible compromise of the exiting nerve roots. On 02/08/2013, she was taken to surgery for laparotomy and lysis of adhesions and exposure of the lumbar 5 and sacral 1 disc space. She was admitted to the hospital on 03/02/2013 for extensive abdominal wound that required daily wound care with a Wound VAC and to address other medical issues. She returned to the office on 07/22/2013 after being in the intensive care unit for approximately 1 month, and then transferred to a skilled nursing facility. She complains of significant postoperative pain in her mid to low back and abdominal region, but this is managed with oral analgesic medications. On exam, she has significant weakness of the bilateral lower extremities. On 07/30/2013, a nursing progress re-assessment note for home health services was submitted, indicating there were no wounds and the skin was intact. She was voiding q.s. and lung sounds were clear. The center abdominal wound was still open, pink and reddish, with visible granulation tissue. On 08/21/2013, a Primary Treating Physician's Supplementary Report and Review of Records indicate that a request had been made for home health services 12 hours a day 7 days a week. It was noted that this patient was a debilitated paraplegic following multiple surgical procedures and a long course of management in the hospital. Diagnoses include postlaminectomy syndrome, bilateral lower extremity radiculopathy, status post cervical discectomy and fusion, status post lumbar interbody fusion, exte

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health services 12 hours per day, 7 days per week for 6: Upheld

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

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

Decision rationale: This request is for home health services 12 hours per day, 7 days per week, for 6 months. The submitted records indicate this patient does have a significant medical history. The records include previous home health nursing notes, indicating that home health had assisted her in showering, bathroom assistance, meal preparation, reminders for medications, light housekeeping, cleaning the bathroom, cleaning the kitchen, making the bed, hair care, oral hygiene, dressing her, taking out the trash, and other household chores. The records do not indicate that home health was substantially giving medical management or medical treatment as there was no indication that home health was doing significant wound care, physical therapy, occupational therapy, or giving injections either for infection or pain control. MTUS Chronic Pain Guidelines indicate that home health services are recommended only for otherwise recommended medical treatment for patients who are home bound, on a part time or intermittent basis, generally of no more than 35 hours per week. The request exceeds that and does not indicate who would be assisting her for the remaining 12 hours per day 7 days per week for the 6 months. The records do not indicate what would happen after the 6 months had occurred. MTUS Chronic Pain Guidelines indicate that 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. While the records do indicate that significant home health care was provided, the records indicate this was in the form of personal care, such as bathing, household chores, assisting with dressing, and assisting with hygiene. The records do not indicate a medical necessity for home health care. As such, this request is not considered medically necessary at this time and is non-certified.