

Case Number:	CM13-0019599		
Date Assigned:	12/04/2013	Date of Injury:	10/30/1998
Decision Date:	01/27/2014	UR Denial Date:	08/11/2013
Priority:	Standard	Application Received:	09/03/2013

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 Family Practice and is licensed to practice in Texas. 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:

The patient is a 62-year-old female who reported a work-related injury on 10/30/1998, as a result of a fall. Subsequently, the patient presents for treatment of the following diagnoses, postlaminectomy syndrome, bilateral lower extremity radiculopathy, status post anterior cervical discectomy and fusion at C3-4, C4-5, C5-6, C6-7 as of 01/10/2005 and 05/05/2008, status post an L2-3, L3-4, L4-5 interbody fusion as of 02/16/2005 with extension of lumbar fusion at T12-L1 and L1-2 as of 10/15/2007 complicated by a staphylococcal infection, extension thoracic fusion T5-L5 as of 04/18/2011, upper extremity radiculopathy, reactionary depression/anxiety, spinal cord implantation as of 04/13/2006, revision of lumbar fusion as well as revision of incision site as of 04/07/2009, intrathecal Dilaudid pump on 10/22/2009, revision of intrathecal infusion pump as of 08/30/2010, acute paralysis as of 09/09/2012, status post bilateral DVT and pulmonary embolism on Coumadin, removal of pedicle screw at T4-5 with placement of pedicle screw at T3 and T4 bilaterally and bilateral T10 laminectomy and bilateral T11 laminectomy and bilateral T12 laminectomy as of 02/04/2013 status post AP fusion at L5-S1 complicated with postoperative infection/ruptured viscous status post implantation of intrathecal baclofen 06/10/2013. The clinical note dated 08/21/2013 indicates primary treating physician's supplemental report and review of medical records and request for authorization by the patient's PCP [REDACTED]. The provider documents the patient is an acute T5 paraplegic, who recently spent 6 months in the hospital status post complications from spinal surgery, the provider documented the patient has abdominal wound requiring dressing changes. The provider documented the patient has the inability to utilize the bathroom, feed herself, and transfer in and out of the bed. The provider documents the patient was initially seen by referring provider in 09/2012 for an acute onset of paralysis.

IMR ISSUES, DECISIONS AND RATIONALES

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

request for daily home health services for six months: Upheld

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

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

Decision rationale: The current request is not supported. The provider documents the patient presents status post multiple surgical interventions performed both to the cervical and lumbar spine. The provider documented the patient underwent surgical interventions in 02/2013 which revealed removal of a pedicle screw at the T4. Postoperatively the patient had increased motor return in her upper extremities as well as to her lower extremities. Approximately 1 week later, the patient underwent further surgical interventions in the form of an AP fusion at L5-S1 status post this surgical intervention the patient spontaneously ruptured her intestine developing an infectious process and underwent further resection and debridement with subsequent removal of the intrathecal pain pump. The wound was left open and the patient developed a small fistula. The provider documents upon physical exam of the patient, she presents with significant functional deficits to the bilateral lower extremities. The provider documented the patient requires assistance with toileting, activities of daily living and transferring (wheelchair to bed). California MTUS indicates that home health services are 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 utilizing the bathroom when this is the only care needed. The provider documented the patient additionally required wound care dressing changes; however, documentation of the patient's course of treatment, the size of the wound, the patient's inability to change the dressings independently, as the clinical notes evidence the patient had bilateral upper extremity strength were not noted. In addition, the current request is for 7 days a week of home health care assistance times 6 months, this is excessive in nature without evaluation of the patient's course of treatment and future progress with cares. Therefore, given all of the above, the request for home health services, 7 days a week for 6 months is not medically necessary or appropriate.