

<b>Case Number:</b>	CM13-0020074		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	05/28/2008
<b>Decision Date:</b>	01/27/2014	<b>UR Denial Date:</b>	08/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2013

### 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 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:

The patient is a 51-year-old female who reported a work-related injury on 05/28/2008. The patient is status post cervical fusion dated 08/21/2013 with a history of L4-5 lumbar laminectomy. Her current diagnoses include bilateral elbow epicondylitis, bilateral carpal tunnel syndrome, and early sign of cubital tunnel syndrome, compression neuropathy of ulnar nerve, cervical sprain/strain, myofascial pain, C5-6 osteophyte complex and lumbar sprain/strain. A request was made for home assistance for 4 hours per week for 8 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Request for home assistance 4 hours per week for 8 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG Low Back Chapter

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

**Decision rationale:** Recent clinical documentation submitted for review stated the patient's symptoms had significantly improved postoperatively. The patient was utilizing Percocet and requested to change pain medications. Objective findings include an intact gait, which was non-antalgic. The postoperative incision was clean, dry and intact. Bilateral upper extremity strength

was 5/5 with sensations noted throughout the bilateral upper and lower extremities with a perception of numbness in the fingertips. Deep tendon reflexes were 1 to 2+ in the bilateral upper extremities. The patient was noted to be using a bone stimulator. The treatment plan included the patient may walk for exercise as tolerated. California Chronic Pain Medical Treatment Guidelines indicate that home health services are recommended only for patients who are homebound, on a part-time or intermittent basis with generally up to no more than 35 hours per week. There is a lack of documentation stating the patient was homebound on a part-time or intermittent basis. There was no documentation stating the patient required recommended medical treatment or home care. Guidelines further state that medical treatment does not include homemaker services or personal care given by home health aides such as bathing, dressing and using the bathroom when this is the only care needed. There was no rationale provided for the request for home assistance for the patient. Given the above, the request for home assistance for 4 hours per week for 8 weeks is non-certified.