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| Case Number: | CM13-0035543 | | |
| Date Assigned: | 12/13/2013 | Date of Injury: | 10/28/2009 |
| Decision Date: | 04/22/2014 | UR Denial Date: | 09/13/2013 |
| Priority: | Standard | Application Received: | 10/17/2013 |

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. The expert 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 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/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 66-year-old female with a date of injury of 10/28/09. The patient has diagnoses of low back pain, lumbar disc degeneration, lumbar facet arthropathy, lumbar disc displacement lumbar radiculopathy, peripheral neuropathy, and chronic pain. The patient has had home health in the past, but for the last two months, she has been without. The physician did not that the pain continued to amplify as a result of not having the home health. The patient was seen on 12/3/13 with chronic low back and bilateral lower extremity pain secondary to a work-related injury. Pain remained suboptimally managed with Fentanyl patches, 70mcg every 48 hours; and oxycodone IR, 10mg every 4 hours with a maximum of 6 per day. Tizanidine 4mg 3 times a day remained well-tolerated for muscle spasms. The patient reported at this office visit that she continued to have functional improvement and improved ability to perform simple household tasks as well as activities of daily living with the current medication regimen. On exam to the lumbar spine, the physician noted tenderness at the L3, L4, and L5 levels with pain centrally and in the facet joints, lumbar range of motion was limited by painful symptoms, and facet loading maneuvers did seem to worsen subjectively. Neurologic exam noted a complaint of bilateral lower extremity discomfort, and numbness in a stocking glove pattern from the mid thigh down. The physician noted a well-coordinated tandem gait.

IMR ISSUES, DECISIONS AND RATIONALES

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

A HOME CARE AIDE, EIGHT HOURS A DAY FOR FORTY HOURS A WEEK FOR TWELVE WEEKS FOR THE LOW BACK.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The patient is a 66-year-old female with diagnoses of low back pain, lumbar disc degeneration, lumbar facet arthropathy, lumbar disc displacement, lumbar radiculopathy, peripheral neuropathy and chronic pain. On the 12/3/13 office visit, the physician was concerned that the patient had not had home health services for two months, and noted that the patient's symptoms continued to amplify as a result. Subjectively, the patient continued to report functional improvement and improved ability to perform simple household tasks as well as increased activities of daily living with the current medication regimen. On exam, the physician did note that for the lumbar spine, there was tenderness at L3-5 with pain centrally and in the facet joints, as well as with some limited range of motion due to the pain symptoms. Guidelines recommend home health only for otherwise recommended patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. There was no documentation stating that the patient is homebound, and if so, why. Also in the documentation, it reports that the patient has had functional improvement and improved ability to perform simple household tasks as well as activities of daily living. Therefore, the request is non-certified.