

Case Number:	CM13-0043365		
Date Assigned:	01/22/2014	Date of Injury:	07/06/2004
Decision Date:	06/06/2014	UR Denial Date:	10/15/2013
Priority:	Standard	Application Received:	10/23/2013

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 Orthopedic Surgery 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 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 50 year old male whose date of injury is 07/08/2004. While loading equipment into his car, the patient lost his balance and fell in a seated position. He primarily noted low back pain. Note dated 04/06/12 indicates that the patient underwent stimulator trial with no relief at all. AME dated 11/14/12 indicates that treatment to date includes lumbar fusion in July 2010, epidural steroid injections, facet joint blocks and spinal stimulation. The most recent note submitted for review is dated 03/08/13. The patient has minimal changes since last evaluation. He complains of ongoing low back pain requiring assistive ambulatory aides with increased pain in the bilateral shoulders, wrists and forearms and left knee. He uses a single-point cane, times two, for ambulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME HEALTH CARE (HOURS AND VISITS UNSPECIFIED) QUANTITY 1.00:

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), Pain.

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

Decision rationale: : Based on the clinical information provided, the request for home health care (hours and visits unspecified) quantity 1/00 is not recommended as medically necessary. There is no current, detailed physical examination submitted for review. The submitted records fail to establish that the patient is homebound on a part-time or intermittent basis as required by CA MTUS guidelines. It is unclear what otherwise recommended medical treatment will be provided to the patient. There is no clearer rationale provided to support home health care at this time. Additionally, the request is nonspecific and does not indicate the frequency and duration of the requested treatment. The request for Home Health Care (hours and visits unspecified) is not medically necessary.