MAXIMUS Federal Services

Case Number:	CM13-0051096		
Date Assigned:	06/09/2014	Date of Injury:	01/25/2010
Decision Date:	08/08/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/19/2013

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 45-year-old woman who sustained a work-related injury on January 25, 2010. Subsequently, the patient developed chronic neck, right elbow, and low back pain. Based on the progress report dated on March 2, 2014 the patient continues to have a severe disability involving the lumbar spine and right elbow. The patient was evaluated by two orthopedic spine surgeons: a two-level lumbar interbody fusion has been requested. The patient rates her pain in the lower back from 0-10 as 8 in intensity, aggravated with any type of bending, twisting, and turning. The patient continues to have neck pain, mostly on the right side. She gets severe and debilitating cervicogenic headaches but the vast majority of her symptoms in the right upper extremity emanates from an ulnar nerve entrapment. On February 28, 2014 the patient underwent a right ulnar nerve decompression. Examination of the posterior cervical musculature reveals tenderness to palpation bilaterally with increased muscle rigidity. There were trigger points palpable and tender throughout the cervical paraspinal muscles, upper trapezius, and medial scapular bilaterally. She had decreased range of motion. Extension is limited to about 10 degrees. Motor testing in the left upper extremity was 5/5 in comparison to the right upper extremity which was 4/5. Examination of the right elbow revealed significant point tenderness to palpation of the right medial epicondyle. There is very noticeable muscle atrophy involving the musculature and soft tissue around the right medial epicondyle and distal triceps surrounding the ulnar nerve. There is a very positive Tinel's sign. There is no evidence of atrophy of the skin or subacute tissue, which might have indicated a reaction to corticosteroid. There is a significant decreased sensation around the medial forearm in the ulnar nerve distribution involving the 5th digit and ulnar aspect of the 4th digit. There is some ulnar clawing of the right hand. There is notable decreased grip strength of the dominant right hand. Examination of the posterior lumbar musculature revealed tenderness to palpation bilaterally with increased muscle rigidity. There are

numerous trigger points that are palpable and tender throughout the lumbar paraspinal muscles, bilaterally. She has decreased range of motion. The patient is able to bend forward without stretched fingers to about 30 degrees, extension is limited to 20 degrees. She had pain with both maneuvers, but worse with flexion. Sensory deficits were decreased with the use of Wartenberg pinwheel along the posterior lateral thigh and posterior lateral calves bilaterally in approximately the L5-S1 distribution. Deep tendon reflexes are in the patellae and trace in the ankles bilaterally. The straight leg raise is positive bilaterally in the modified sitting position at about 60 degrees which causes radicular symptoms. Lumbar spine MRI performed on July 25, 2012 showed 2 mm disc protrusion at L5-S1. This needs to be reviewed as her previous MRI revealed moderate to severe bilateral facet arthropathy. EMG of the upper and lower extremities performed on March 19, 2012 revealed a left L5 radiculopathy. There is mild to moderate chronic denervation of the right ulnar nerve with entrapment of the right elbow and mild on the left side.Cervical spine MRI performed on March 22, 2011 revealed at C4-5, C6-7 mild narrowing of the right and left lateral recess.Right elbow MRI performed on July 9, 2010 noted fluid under the right elbow joint, negative for fractures. Urine drug testing was performed on March 2, 2014. For the patient's debilitating symptoms, she required numerous medications (Oxycontin, Nucynta, Neurontin, FexMid, Xanax, Ambien, Doxepin, Prilosec, Colace). Consequently, she has had severe pain in her abdomen with GI discomfort. The patient's assessment is: lumbar myoligamentous injury with bilateral lower extremity radicular symptoms, left greater that right, with associated moderately severe facet arthropathy; cervical myoligamentous injury; right ulnar nerve entrapment, s/p release on February 28, 2014; reactionary depression/anxiety; and medication induced gastritis. The provider requested authorization for home health aide.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME HEALTH AIDES 2 HOURS A DAY THREE DAYS A WEEK: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Online Version, Pain Chapter.

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

Decision rationale: According to MTUS guidelines, home care is recommended only for 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 using the bathroom when this is the only care needed. (CMS, 2004). The patient does not fulfill the requirements mentioned above. There is no documentation that the patient recommended medical treatment requires home health aide. The patient is not homebound. Its home situation is unclear. The provider may clarify the patient needs for home health aid that do not include activity of daily living such as shopping, cleaning and cooking. Therefore the request for Home Care Assistance is not medically necessary.