

Case Number:	CM13-0068231		
Date Assigned:	01/03/2014	Date of Injury:	02/07/2000
Decision Date:	06/23/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/19/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine, 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 injured worker is a 53-year-old female who reported an injury on 02/07/2000. The mechanism of injury was cumulative trauma. The documentation of 11/12/2013 revealed the injured worker had pain from the thoracic epidural electrodes for the spinal cord stimulator. The injured worker had pain over the implantable pulse generator (IPG) battery site. She had increased pain in the upper extremities, and a right upper extremity tremor along with right leg spasticity. A physical examination revealed the injured worker's gait was slow and her stance was short. The injured worker had a right upper extremity tremor and a right leg spasticity. The cervical spine and lumbar spine range of motion was limited and guarded. The diagnoses included complex regional pain syndrome of the left upper extremity status post spinal cord stimulator implantation complicated by numerous revision surgeries with lead migration and chronic IPG discomfort, bilateral carpal tunnel syndrome, upper extremity peripheral entrapment neuropathy, two (2) cerebrovascular accident, chronic pain syndrome and right upper extremity tremor and right leg spasticity. The treatment plan included a home care assistant due to severe loss of upper and lower extremities, transportation, a urologist for incontinence, a dental evaluation, laboratory studies, a neurology consult, Ambien 20 mg by mouth at bedtime, gabapentin 600 mg by mouth 3 times a day, Zofran 4 mg by mouth 3 times a day for nausea, omeprazole 20 mg by mouth 3 times a day for GERD and Biotene mouthwash for xerostomia.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTINUE HOME CARE ASSISTANCE FOR FIVE (5) HOURS A DAY, FIVE (5) DAYS A WEEK FOR TWO (2) MONTHS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN, HOME HEALTH SERVICES, 51

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

Decision rationale: The MTUS Chronic Pain Guidelines recommend home health services for injured workers who are homebound and are in need of intermittent medical treatment for up to 35 hours. Intermittent treatment does not include homemaker or aide type services. The clinical documentation submitted for review failed to indicate the injured worker had a necessity for medical services. There was a lack of documentation of the type of services being requested. Given the above, the request for continue home care assistance for five (5) hours a day, five (5) days a week for two (2) months is not medically necessary.