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| Case Number: | CM14-0018740 | | |
| Date Assigned: | 04/18/2014 | Date of Injury: | 07/21/2012 |
| Decision Date: | 07/03/2014 | UR Denial Date: | 02/06/2014 |
| Priority: | Standard | Application Received: | 02/13/2014 |

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 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 injured worker is a 56-year-old female who reported an injury on 07/21/2012. The mechanism of injury was not stated. Current diagnoses include displaced cervical intervertebral disc and degeneration of the cervical intervertebral disc. The injured worker was evaluated on 01/09/2014. The injured worker reported persistent cervical pain. Previous conservative treatment includes acupressure therapy, massage therapy, chiropractic therapy, ice/heat therapy, a home exercise program, over-the-counter medication, prescription analgesics, occupational therapy, and physical therapy. Physical examination revealed tenderness to palpation of the cervical spine, moderate spasm in the trapezius on the left, diminished strength in the left upper extremity and hypoesthesia in the C6 distribution on the left. Treatment recommendations at that time included an anterior discectomy with disc replacement at C5-6.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST-OP IN HOME SUPPORT CARE FOR 2-3 WEEKS: 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: California MTUS Guidelines state home health services are recommended only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis, generally up to no more than 35 hours per week. The specific frequency of treatment was not listed in the request. The type of services required were not mentioned. There is no indication that this injured worker's surgical procedure has been authorized. There is also no indication that this injured worker will be homebound following surgery. Based on the clinical information received and the California MTUS Guidelines, the request is not medically necessary.