

Case Number:	CM14-0121183		
Date Assigned:	08/06/2014	Date of Injury:	05/05/2011
Decision Date:	09/18/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	07/31/2014

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 Emergency Medicine 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 has a reported date of injury on 5/5/2011. Mechanism of injury is described as a back injury while lifting and losing balance. Patient has a diagnosis of chronic pain syndrome, R hip pain post fracture, bilateral hip/pelvic contractors, unequal leg length (acquired), medial epicondylitis, muscle spasms and peripheral neuropathy. Medical records reviewed. The last report is available until 7/11/14. Patient complains of L wrist and R hip pain. The reported occasional falls and difficulty getting out of bed. Pain to hip is severe and unable to stand for more than a few minutes. Objective exam reveals R sided antalgic gait, R Trendelenburg gait, unsteady and wide based and uses a rolling walker with L wrist deformity. Their request for home health aid is due to expected difficulties in upcoming hip surgery in the future to help perform daily ADLs. The request for home health aid is noted on note from 4/16/14 to "improve function"; 6/4/14 to assess home health needs to address "ability to do ADLs, dressing, showering, cooking, cleaning, driving her to appointments, shopping and dispensing medications. No imaging reports provided for review. Patient reportedly completed aqua therapy. Current medication noted to be Oxycontin, Roxicodone, Trazodone, Zanaflex, Zofran, Ativan, Cymbalta and Enalapril. Independent Medical Review is for Home Health Care 4hours/day 5days/week for 6months. Prior UR on 7/21/14 recommended denial.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health care 4 hours a day 5 days a week for 6 months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 2010 REVISION, WEB EDITION, PG 51.

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

Decision rationale: As per MTUS chronic pain guidelines, home health aide may be recommended for medical treatment in patients who are bed or home bound. However, the requesting physician has failed to provide documentation to support being home bound and in need for a home health aide. There are notes specifically describing services needed for the home health aide that is expressly defined as "homemaker service" which is expressly not the services that home health services is for. Home Health Service is not medically necessary.