

Case Number:	CM14-0153952		
Date Assigned:	09/23/2014	Date of Injury:	11/01/2013
Decision Date:	10/24/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	09/22/2014

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 & Rehabilitation has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 male who reported an injury on 01/01/2013. The mechanism of injury was not provided. The injured worker had the diagnoses of cervical disc displacement and cervical radiculopathy. The past medical treatment included medications, physical therapy, and surgery. Diagnostic testing included a CT scan of the cervical spine done on 08/21/2014 and an MRI of C spine, date was not provided. The injured worker underwent microsurgical discectomy and foraminectomy at C5-6 and C6-7 with fusion on 03/19/2014. The injured worker complained of upper extremity altered sensation and complained of tingling with pain on 06/04/2014. The injured worker described the severity as being moderate in degree. The physical examination revealed tingling to right 1st through 4th fingers, volar aspect only. Medications included cyclobenzaprine, Gabapentin, hydrocodone/acetaminophen, and Motrin. The treatment plan is for homemaker services, unspecified frequency and duration. The rationale for the request was not submitted. The Request for Authorization Form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Homemaker Services; unspecified frequency and duration: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services.

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

Decision rationale: The request for Homemaker Services; unspecified frequency and duration is not medically necessary. The injured worker complained of upper extremity altered sensation and complained of tingling with pain on 06/04/2014. The California MTUS guidelines state Home Health is 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. 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. There is a lack of documentation stating the injured worker is homebound or unable to care for themselves. There is a lack of documentation indicating the injured worker has significant objective functional deficits. There is no documentation indicating the injured worker would require medical services, as opposed to solely assistance with homemaking tasks. In addition the request failed to specify frequency and duration of homemaker services. Therefore the request for Homemaker Services; unspecified frequency and duration is not medically necessary.