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| Case Number: | CM14-0020988 | | |
| Date Assigned: | 04/30/2014 | Date of Injury: | 06/19/2005 |
| Decision Date: | 07/08/2014 | UR Denial Date: | 02/04/2014 |
| Priority: | Standard | Application Received: | 02/19/2014 |

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 Occupational 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:

This patient is a 43 year-old female with date of injury 06/19/2005. The report associated with the request for authorization is dated 12/18/2013. It states that on 07/26/2013 the patient underwent a T10 to pelvis fusion and lateral mass fusion from L3-4 to L4-5. The primary issue associated with the request is problems with toileting. The most relevant history and physical associated with the request for authorization, a primary treating physician's progress report, dated 08/21/2013, lists subjective complaints as some back pain with numbness and weakness in the right anterior thigh and groin area. Objective findings: Examination of the lower extremities revealed depressed knee jerk on the right side, active on the left. Sitting straight leg test was satisfactory. Quadriceps strength on the right side was 4; on the left was 5. There was hypesthesia in the anterior and lateral thigh on the right side. Diagnosis: 1. Thoracic/lumbosacral neuritis/ radiculitis 2. Displacement intervertebral disc without myelopathy 3. Lumbar strain/sprain.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME HEALTH AID, (8) HOURS PER DAY, (5) DAYS PER WEEK, FOR (6) WEEKS:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Home Health Services.

Decision rationale: The Official Disability Guidelines recommend home health services only for recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis. 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. The medical record does not contain documentation that the patient requires medical services to be provided at the home. home health aid, (8) hours per day, (5) days per week, for (6) weeks is not medically necessary.