

<b>Case Number:</b>	CM14-0023564		
<b>Date Assigned:</b>	05/07/2014	<b>Date of Injury:</b>	01/15/2011
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	01/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/21/2014

### 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 Orthopedic Surgery 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 42 year old male whose date of injury is 01/15/2011. The injured worker developed pain in his groin with swelling and pain in the left testicle which he attributed to the constant heavy lifting and carrying of metal material. Treatment to date includes hernia repair in September 2009 and removal of metal debris from his right hand in November 2010. The injured worker was recommended to undergo posterior lumbar interbody fusion at L5-S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HOME HEALTH:** 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 HOME HEALTH SERVICES Page(s): 51.

**Decision rationale:** Based on the clinical information provided, the request for home health assistance is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the injured worker's response there to submitted for review. There is no current, detailed physical examination submitted for review and no home assessment was provided. California Chronic Pain Medical Treatment Guidelines support home health

services for injured workers who are homebound on a part-time or intermittent basis which is not documented in the submitted records. The specific medical treatment to be provided is not documented. The request does not indicate the frequency and duration of requested home help. Given all the above the request is not medically necessary.