

<b>Case Number:</b>	CM14-0028561		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	12/18/2006
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	02/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2014

### 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 Family Practice and is licensed to practice in Mississippi and Texas. 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 who reported an injury on 12/11/2006 due to unknown mechanism. The injured worker complained of low back pain, bilateral hip pain and, left leg pain, and rated pain at 8/10 on the pain scale. On physical examination dated 05/15/2012 there was tenderness to palpation noted over the multifidus, longissimus, and ilocostalis muscles bilaterally. Range of motion of the lumbar spine flexion was at 30 degrees, extension at 10 degrees, right lateral bending at 15 degrees, left lateral bending at 10 degrees. The injured worker's diagnoses include degenerative disc disease, lower extremity pain, spondylolisthesis, lumbar sacral, and facet arthrosis and stenosis lumbar spine. The injured worker's medication Motrin, and Advil. The treatment plan was for home health care 4 hours day 3 days a week. The request for authorization form was not submitted with documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 HOME-HEALTH CARE 4 HOURS A DAY 3 DAYS A WEEK: 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), Pain (Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Medical Treatment Guidelines: Home health services.

**Decision rationale:** The request for home health care 4 hours a day 3 days a week is not medically necessary. The California Medical Utilization Schedule (MTUS) states that home health services are recommended only for otherwise medical treatment for patients who are homebound, on a part-time or intermittent basis generally up to no more than 34 hours per week. This medical service does not include homemaker services like shopping, cleaning, laundry, or personal care given by a home health aide like bathing dressing and using the bathroom when this is the only care needed. The injured worker was complaining of pain, and according to the clinical note dated 05/15/2012 the injured worker was attending physical therapy. Guidelines also state that home health services does not include health aide services like shopping, cleaning, laundry, or personal care given by a home health aide like bathing, dressing, and using the bathroom when this is the only care needed. There is no mention of a clinical reason or rationale in the documentation dated 05/15/2012 to establish medical need for the request for home health services. As such the request is not medically necessary .