

Case Number:	CM14-0028747		
Date Assigned:	06/16/2014	Date of Injury:	02/01/2001
Decision Date:	07/22/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	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 Physical Medicine and Rehabilitation 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 is a 50 year old male who was injured on 02/01/2001. The mechanism of injury is unknown. Prior treatment history has included physical therapy. The patient underwent a left total hip arthroplasty revision on 03/06/2013. Prior medication history included oxycontin, Colace, simlax, Norco, Miralax. Diagnostic studies reviewed include x-ray of bilateral lateral hip follow up dated 01/09/2014 revealed bilateral total hip arthroplasties, anatomically aligned. Progress report dated 01/24/2014 documented the patient presented with wrist pain. The patient rated his pain as 5/10 and the highest pain level is 10/10. He describes it as aggravated with certain movement. He has associated numbness in his right fingers. On exam, he walks with a slight limp and uses cane. He has a right splint and can't fully close right hand. Diagnoses are tenosynovitis, De Quervain. The treatment and plan included triangular fibrocartilage complex and closed Barton's fracture of radius with malunion and status post carpal tunnel release. The treatment and plan included EMG/NCV, injection, extensive occupational therapy. Of note, x-ray of the left forearm revealed malunion of the distal radius with shortening and angulation. Prior utilization review dated 02/04/2014 states the request for continuation with home aid 8 hrs a day, 7 days a week, for 8 weeks is not certified as additional information was not provided as requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTINUE WITH HOME AID 8 HRS A DAY, 7 DAYS A WEEK, FOR 8 WEEKS;;

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 based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Home health services.

Decision rationale: The CA MTUS guidelines and ODG recommend the use of home aid for medical treatment in patients who are homebound, on a part-time or "intermittent" basis. The medical records document that the patient had total hip arthroplasty revision followed by a course of physical therapy and has ongoing wrist pain secondary to the injury. However, the documents do not show what limitations the patient would have at home or what the functional outcome would be with the use of home aid. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.