

<b>Case Number:</b>	CM14-0039195		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	02/28/2003
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	03/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2014

### 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,, has a subspecialty in Pain Management 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 61-year-old with an injury date February 28, 2003. The listed diagnoses per [REDACTED] dated February 28, 2014 are status post pulmonary embolism requiring chronic anticoagulation, andoxygen, peripheral vascular disease, lumbago, and status post left hip 3, total hip replacement. According to this report, the patient complains of left hip pain and mid back pain. The patient is morbidly obese, who presents in a walker using nasal cannula oxygen. The patient was able to undress and get on and off theexamining table without assistance. The patient's current medications areCoumadin, Simvastatin, Oxygen, Amlodipine, Losartan and uses CPAPevery night for sleep apnea. There were no other significant findings noted on this report. The utilization review denied the request March 18, 2014. [REDACTED] is the requesting provider, and he provided treatment reports from September 20, 2013 to May 16, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One home health assistance, eight hours per day:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Benefits Manual (Rev. 144, 05-06-11), Chapter 7-Home Health Services; section 50.2(Home Health Aide Services).

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

**Decision rationale:** According to the February 28, 2014 report by [REDACTED] this patient presents with left hip pain and mid back pain. The treater is requesting for one home health assistance, 8 hours per day. The UR denial letter state "The current treatment guidelines only allow for this type of service to be provided on a part time or intermittent basis not exceeding 28 hours per week", therefore the certified with modification, to allow for #4 hours per day. Regarding the provider's request for home care, The Chronic Pain Medical Treatment Guidelines recommend medical treatment for patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. The Chronic Pain Medical Treatment Guidelines typically do not consider homemaking services such as shopping, cleaning, laundry, and personal care, medical treatments if this is the only service asked for. The treater does not explain what the 8 hours per day is to include for home health care. A home OT evaluation may be necessary to determine the need. Current request for eight hours per day exceeds the 35 hour/wk maximum allowed by the Chronic Pain Medical Treatment Guidelines and given the lack of description of what service is needed, recommendation is for denial.

**An unknown prescription of Coumadin:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Page(s): 8.

**Decision rationale:** According to the February 28, 2014 report by [REDACTED] this patient presents with left hip pain and mid back pain. The treater is requesting unknown prescription of Coumadin. The UR denial letter states In regard to the request for Unknown prescription of Coumadin, the reviewer determined that additional information was reasonably necessary in order to render a decision, and please indicate the exact quantity and dosage for the requested prescription of Coumadin. Review of the reports still do not show prescription dosing and how this medication is being monitored and for what condition it is prescribed. The progress reports discussing this medication is not provided for this review. Without the pertinent information, this request cannot be considered. The Chronic Pain Medical Treatment Guidelines requires that the treater provide monitoring of the patient's progress. The request for an unknown prescription of Coumadin is not medically necessary or appropriate.