

<b>Case Number:</b>	CM14-0081077		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	09/04/2001
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2014

### 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 Orthopedic Surgery and is licensed to practice in 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 52-year-old female who suffered multiple and cumulative work-related injuries from September 4, 2000 through September 4, 2001 while under the employment of [REDACTED]. She was diagnosed with: chronic pain state, especially relative to the right shoulder/upper extremity and neck; fibromyalgia with chronic fatigue; chronic headaches, mixed type; anxiety, depression, insomnia; gastroesophageal reflux disease/dyspepsia; asthma, industrial; rhinosinusitis, industrial, status post surgery performed on January 25, 2005; osteopenia; dental problems; dysphagia, representing a conversion reaction; scalp and feet dermatoses of unknown etiology; pseudoseizures; and Morgellons disease (delusional parasitosis). As per medical records reviewed, the injured worker has been previously diagnosed with fibromyalgia since the 1990s following a motor vehicular accident. She has also been diagnosed with industrially-related steroid withdrawal syndrome. The injured worker has a known history of opioid dependency, multiple falls and hospitalizations due to "multiple shaking" and failure to thrive. Since the date of injury, the injured worker has been provided home care by caregivers for four to six months (dates not specified), which was eventually changed to licensed vocational nurses assistance for 24 hours a day for 8 months (no date specified). Gastroenterology evaluation report dated January 14, 2013 noted complaints of nausea, vomiting, and constipation. She has lost 25 to 40 pounds but was "not sure" over what period. However, she indicated she has "good appetite." Prior computed tomography scan of the abdomen and pelvis (no procedure date specified) were reviewed during this evaluation date which showed unremarkable results. Progress note dated March 24, 2014 noted the injured worker report stating she suffered from two occasions of stress-induced seizure the week prior. She reported some difficulty swallowing and "burning", upper central abdominal pain. Abdominal examination was significant for slight epigastric tenderness to palpation. Progress

note dated May 5, 2014 noted the injured worker's reports of experiencing right upper quadrant abdominal pain with radiation to the back. There were no physical examination findings for the abdomen. The treating physician requested home health care and monitoring 24 hours a day for seven days a week as he "believes she is currently a danger to herself from a medical/ health standpoint." Recent case management closure reports from May 1, 2014 through June 2, 2014 were reviewed. Reports indicated the injured worker is being cared for by her son who performs activities such as "providing food, clean clothing, clean bedding, ensuring she shows and attends to hygiene activities as tolerated." The injured worker indicated pain to her neck, right shoulder, and low back as well as difficulty in swallowing due to mouth and throat discomfort. She continued to persevere on her complaint of "pieces of asbestos coming out of my body" and objective examination findings were significant for labile moods as the home visits progressed.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**7 Home Health Care Aide and monitoring for 24 hours per day, for 7 days per week (no end date) related to abdominal pain as outpatient.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [https://www.acoempracguides.org/Chronic Pain](https://www.acoempracguides.org/ChronicPain); Table 2, Summary of Recommendations, Chronic Pain Disorders.

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

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend home health services for patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. In this case, the medical records submitted does show evidence that the injured worker is unable to fully perform purposeful daily activities due to the interplay of her complex and multifactorial symptoms, in particular her psychological state. However, the documentation submitted does not specifically indicate primary disability secondary to the injured worker's gastrointestinal complaints. Additionally, home health care services in excess of 35 hours per week are not supported by the guideline recommendations and the request for 24 hours per day for 7 days a week monitoring does not meet the guidelines. Therefore, it can be concluded that the 7 home health care aide and monitoring 24 hours per day, for 7 days per week (no end date) related to abdominal pain as an outpatient is not medically necessary at this time.