MAXIMUS Federal Services

| Case Number: | CM14-0088726 | | |
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| Date Assigned: | 07/23/2014 | Date of Injury: | 01/14/1983 |
| Decision Date: | 09/18/2014 | UR Denial Date: | 06/04/2014 |
| Priority: | Standard | Application Received: | 06/12/2014 |

## 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 Internal Medicine, 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 76-year-old who sustained injury on January 14, 1983. The mechanism of injury was not reviewed. Echocardiogram dated May 19, 2014 showed ejection fracture of 45-60% range. A progress note dated May 19, 2014 indicates he was hospitalized for increasing SOB and was taken and found to be in CHF and given IV diuretics with a good result. He remains in a wheelchair and feels weak and washed out, but his breathing is better and he has no peripheral edema today. Medications including Allopurinol, Cardizem, Lasix, Leukeran, Lisinopril, Metoprolol, Omega 3, Pepcid, Potassium chloride, Spironolactone, Synthroid, Vicodin, Vytorin, and Zofran. Physical exam showed blood pressure was 110/70, pulse was 90-100 and irregularly irregular. Weight 160 pound and height 72.5". Chest clear without wheezes, rhonchi, rales, or rubs. Cardiac exam showed no jugular venous distention. There was no rub. He had a 1/6 systolic murmur. Carotids were 2+ and equal bilaterally without bruits. There was no S3, S4, open synop, or ejection click. Extremities showed 1+ right and left ankle edema, but no calf tenderness. CNS exam was grossly within normal limits. Impression was congestive heart failure secondary to congestive cardiomyopathy, coronary artery disease post bypass surgery and AVR, chronic atrial fibrillation, chronic lymphocytic leukemia, and pericardial effusion postop received with pericardial window. UR report dated June 4, 2014 indicates the request for home health service is non-certified because there is no documentation of what functions the caregiver will need to provide.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Respite care in home, three to four hours daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

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

**Decision rationale:** The guidelines recommend home health services for medical treatment for patients who are homebound. The services do not include homemaker services such as cooking, cleaning, or shopping. The clinical documents did not identify what specific home health services are requested. It is evident the patient is severely ill and on hospice care. However, hospice generally has the means available to care for all of their patients' medical needs. Based on the guidelines and clinical documents provided, the request for respite care in home, three to four hours daily, is not medically necessary or appropriate.