

<b>Case Number:</b>	CM14-0093225		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	03/18/2011
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2014

### 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 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 50-year-old female who sustained an injury to her whole body due to a fall from a ladder on 03/18/11. Clinical note dated 05/14/14 reported that the injured worker complained of total body pain, right lower extremity atrophy/weakness, and depression/anxiety. The records indicate that the injured worker has been treated conservatively, but developed worsening symptoms. The injured worker was subsequently diagnosed with chronic regional pain syndrome. Other treatments have included sympathetic blocks. Physical examination was technically difficult due to severe allodynia and guarding; the injured worker had bilateral frozen shoulder; weakness of the bilateral lower extremities; transitional lumbar anatomy on radiographs; cervical spine x-rays revealed degenerative disc disease. Urinary drug screen was positive for Hydrocodone, consistent with the injured worker's prescribed drug regimen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transportation for all activities:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg chapter, Transportation (to & from appointments).

**Decision rationale:** The Expert Reviewer's decision rationale: The request for transportation for all activities is not medically necessary. The previous request was denied on the basis that this is not a medical service for the cure or relief of an industrial injury and is therefore not within the scope of utilization review as described by the current literature. The ODG states that transportation to and from appointments is recommended for medically necessary appointments in the same community for injured workers with disabilities preventing them from self-transport. There was no information provided that would indicate any comorbidity as to why the injured worker cannot ambulate to appointments by her own means (family, friends, public transportation, etc). After reviewing the submitted documentation, there was no additional significant objective, clinical information provided that would support reverse of the previous adverse determination. Furthermore, the frequency/duration is not specified in the request therefore, this request is not medically necessary.

**Home care assistant 4 hours daily and 7 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, Low back chapter.

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

**Decision rationale:** The Expert Reviewer's decision rationale: The request for home care assistant 4 hours daily and 7 days a week is not medically necessary. The previous request was denied on the basis that home health services are recommended only for medical treatment for patients who are homebound on a part time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing and using the bathroom when this is the only care needed. In this case, the records indicate severe pathology that was documented by various other providers. However, there was no clear need for specialized home care such as skilled nursing care, physical, occupational or speech language therapy. It was noted that the request was made for home assistance for services like shopping, cleaning, laundry, and personal care. The records indicate that the injured worker already has assistance at home. Furthermore, the duration was not specified in the request. Given this, the request for home care assistant 4 hours daily and 7 days a week therefore, this request is not medically necessary.