

Case Number:	CM14-0199585		
Date Assigned:	12/10/2014	Date of Injury:	04/01/2003
Decision Date:	01/31/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/01/2014

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 injured worker is a 66-year-old woman with a date of injury of April 1, 2003. The mechanism of injury was not documented in the medical record. The injured worker's working diagnoses are status post lumbar hardware removal with irrigation and debridement on December 24, 2013; status post L2-L3 and L3-L4 TLIF with hardware removal L4-S1 on April 11, 2013; status post multiple I&Ds lumbar incisions May of 2013; history of right sided laminotomy, L4-L5; and status post revision decompression and posterior spinal fusion, L4-L5 in February 2005. There is a single progress report in the 18 page medical record dated April 28, 2014. The provider reports that the IW is currently in a skilled nursing facility, and will likely be discharged in a few days. The only objective documentation reports alert and oriented with fluent speech, and she is ambulating well with a walker. According to the UR documentation, the IW is status post posterior fusion at T12-L3 and revision to L2-L3 on August 5, 2014. The medical record did not contain documentation of the injured worker's current physical limitations. There are no post op progress reports available for review. There are no current progress notes available for review. The current request is for Home Health Assistant (HHA) 3 hours a day per week for 2 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health aide 3 hours a day, 3 days a week for 2 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Home Health Services

Decision rationale: Pursuant to the Official Disability Guidelines, home health aide three hours a day, three days a week for two weeks is not medically necessary. These services include both medical and nonmedical services for patients who are homebound and who require one or combination of the following: 1) skilled nursing care of by a licensed medical professional for tasks such as administration of IV drugs, dressing changes, physical therapy, speech language pathology services in occupational therapy; 2) home health aide services for health-related tasks and assistance with activities of daily living that do not require skills of the medical professionals such as bowel and bladder care, feeding, bathing, dressing and transfer and administration of oral medications; and or 3) domestic services such as shopping, cleaning, laundry and the individual is no longer capable of performing the services due to illness or injury. In this case, the injured worker is 66 years old with a date of injury April 1, 2003. The injured worker status post multiple lumbar surgeries with the most recent on August 5 of 2014. There is a single progress note in the medical record dated April 28, 2014. The injured worker ambulates with a walker. There is no recent documentation in the medical record on or about the date of request November 13, 2014. There is no documentation indicating whether skilled nursing care is required. There is no indication the injured worker is homebound. Overall, there is no medical documentation to support home health aide. Consequently, absent the appropriate clinical documentation home health aide three hours a day three days a week for two weeks is not medically necessary.