

Case Number:	CM14-0204860		
Date Assigned:	12/17/2014	Date of Injury:	09/18/2006
Decision Date:	02/10/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/08/2014

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 Rehab, has a subspecialty in Pain 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:

This is a male patient with the date of injury of September 18, 2006. A Utilization Review dated November 26, 2014 recommended non-certification of in-home aid 4 hours/day x 4 days/wk and certification of repeated series of right SGB x3. A Progress Report dated November 10, 2014 identifies History of Present Illness of obtained >50% pain relief and functional improvement with decreased medication requirements lasting >6 weeks from lumbar sympathetic block on 9/11/14. The patient reports increased right hand and forearm pain, described as a burning pain. She also reports increased left low back pain but no change in distribution. Physical Exam identifies tenderness to palpation L4-L5 paraspinals. Decreased lumbar ROM. Strength is decreased RUE and RLE, in part limited by pain. There is hyperalgesia and allodynia noted to the right lower extremity with erythema. Left hip and thigh with increased tenderness with symptoms of CRPS on left LE. Assessment identifies s/p SCS implant, pain in joint: ankle and foot, pain in joint: lower leg, pain in joint: pelvic region and thigh, pain in joint: hand, pain in joint: forearm, pain in joint: upper arm, pain in joint: shoulder region, reflex sympathetic dystrophy of the lower limb, and reflex sympathetic dystrophy of the upper limb. Treatment identifies await authorization for in-home aid to assist with cleaning, cooking and shopping for 4 hours/day x4 days/week and request authorization for repeated series of right SGB.

IMR ISSUES, DECISIONS AND RATIONALES

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

In-home aid 4hours per day times 4 days per week: Upheld

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

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

Decision rationale: Regarding the request for in-home aid 4hours per day times 4 days per week, California MTUS states that home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, and medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Within the documentation available for review, there is no documentation that the patient is homebound and in need of specialized home care (such as skilled nursing care, physical, occupational, or speech-language therapy) in addition to home health care. In the absence of such documentation, the currently requested in-home aid 4hours per day times 4 days per week is not medically necessary.

Repeated series of right SGB times 3: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS (Effective July 18, 2009), 8 C.C.R. 9792.20 - 9792.26 Page(s): 103-104. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, CRPS, sympathetic blocks (therapeutic)

Decision rationale: Regarding the request for repeated series of right SGB times 3, Chronic Pain Medical Treatment Guidelines state that stellate ganglion blocks are generally limited to diagnosis and therapy for Complex Regional Pain Syndrome (CRPS). ODG state that there should be evidence that all other diagnoses have been ruled out before consideration of use, as well as evidence that the Budapest criteria have been evaluated for and fulfilled. The guidelines go on to state that if a sympathetic block is utilized for diagnosis, there should be evidence that the block fulfills criteria for success including increased skin temperature after injection without evidence of thermal or tactile sensory block. Documentation of motor and/or sensory block should also occur. For therapeutic injections, guidelines state that they are only recommended in cases that have positive response to diagnostic blocks and diagnostic criteria are fulfilled. Within the documentation available for review, there is there is note of functional improvement and decreased medication use after previous injections. As such, the currently requested repeated series of right SGB times 3 are medically necessary.