

Case Number:	CM15-0191742		
Date Assigned:	10/05/2015	Date of Injury:	04/10/1990
Decision Date:	11/18/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	09/29/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Family Practice

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 an 81 year old male who sustained an industrial injury on 04-10-1990. A review of the medical records indicated that the injured worker is undergoing treatment for cervical radiculopathy, Grade II isthmic spondylolisthesis (L5-S1) and left rotator cuff tear. According to the treating physician's progress report on 08-28-2015, the injured worker continues to experience low back pain radiating to the left leg with numbness and tingling and increased weakness in the right leg causing balance issues. Some of the objective findings were difficult to decipher. Examination noted increased pain with sitting to standing position and increased pain to the left leg when lying down. Straight leg raise was positive at 80 degrees on the left. Muscle strength was diminished. The injured worker uses a walker. Prior treatments have included diagnostic testing, lumbar epidural steroid injections (3rd injection in 01-2015), walker and medications. Current medication was listed as Tramadol. Neurontin was discontinued secondary to eye problems. On 08-28-2015, the provider requested authorization for home aid (unspecified frequency/duration) Qty: 1.00. On 09-11-2015, the Utilization Review determined the request for home aid (unspecified frequency/duration) was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home aid (unspecified frequency/duration) Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

Decision rationale: Per the MTUS guidelines, Home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. 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. In this case, the medical records note that a peer discussion was performed at the time of the original Utilization Review at which time an agreement was reached for an RN evaluation should be requested to evaluate the medical needs and the duration of assistance. The medical records do not indicate that an RN evaluation is being requested and the request for Home aid (unspecified frequency/duration) Qty: 1.00 is not medically necessary and appropriate.