

<b>Case Number:</b>	CM15-0205106		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	06/28/1993
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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: Texas, 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 a 62 year old male who sustained an industrial injury 06-28-93. A review of the medical records reveals the injured worker is undergoing treatment for neck-discogenic pain post fusion, thoracic-lumbar pain with chronic radiculopathy, carpal tunnel syndrome, bilateral knee pain and internal derangement, and bowel function disruption. Medical records (09-21-15) reveal the injured worker feels like he is "getting worse every day." The patient had an electric shock like pain in back and arm. He reports that he has been in bed most of the day at least 5 days per week due to increased neck, back, and extremity pain, as well as abdominal pain and diarrhea. The physical exam (09-21-15) reveals exquisite tenderness to palpation of the left knee with trace effusion and of the left lateral epicondyle with numerous ecchymosis of the bilateral upper extremities. "Severe" cervical and lumbar paraspinal spasms with active trigger points are reported. The injured worker is noted to have an antalgic gait, and to ambulate without assistive devices. The patient had positive bowel sounds and tenderness on abdominal examination. There is no documentation of functional limitations of the injured worker. Prior treatment includes cervical fusion, medications, psychologist and pain management referrals, and a greater occipital nerve block. The patient sustained the injury when he was pulling a cart. The medication list include Alprazolam, Cymbalta, Nexium, Robaxin, Tizanidine, Neurontin, Tramadol and Oxycodone. The patient had EMG of upper extremity that revealed cervical radiculopathy and MRI of the cervical spine that revealed foraminal narrowing, and fusion. The patient's surgical history include cervical and lumbar fusion in past. Patient had received a

lumbar ESI for this injury. The patient has had a history of anxiety and depression. Per the note dated 7/27/15 the patient was living with his [REDACTED] and [REDACTED].

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Caregiver 4 hours per day for functional decline:** Upheld

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

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

**Decision rationale:** Per the CA MTUS guidelines cited below, regarding home health services "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." The injured worker is noted to have an antalgic gait, and to ambulate without assistive devices. There is no documentation of significant functional limitations in the injured worker, preventing him from doing activities of daily living. A documented evidence that patient is totally homebound or bedridden is not specified in the records provided. A medical need for home health services like administration of IV fluids or medications or dressing changes is not specified in the records provided. Homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not considered medical treatment. Per the note dated 7/27/15 the patient was living with his [REDACTED] and [REDACTED]. The detailed rationale for the request for a Caregiver 4 hours per day for functional decline is not specified in the records provided. Response to conservative therapies and previous therapy notes were not specified in the records provided. The medical necessity of the request for Caregiver 4 hours per day for functional decline is not fully established in this patient. The request is not medically necessary.