

<b>Case Number:</b>	CM15-0207401		
<b>Date Assigned:</b>	10/27/2015	<b>Date of Injury:</b>	07/26/2013
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	09/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 42-year-old female who sustained an industrial injury on 7/26/13. Injury occurred relative to a fall down stairs. She underwent right ankle Brostrom repair with wound dehiscence and infection requiring a second surgery. She was diagnosed with Type 1 CPRS (complex regional pain syndrome) right ankle. She underwent a spinal cord stimulator trial on 7/17/15 with 65% improvement in pain and improvement in functional ability. The 8/26/15 treating physician report indicated that the injured worker was scheduled for permanent placement of a spinal cord stimulator on 8/26/15. She was very concerned about her ability to mobilize. She was unable to mobilize at all after the previous stimulator trial. Home health care evaluation and management for the first two weeks after spinal cord stimulator placement was recommended due to inability to mobilize. Physical therapy during the post-operative period was also recommended. Physical exam documented no change in exam. She could not really move the ankle and had hypersensitivity to the region. She continued on crutches with minimal weight bearing. She needed emotional and physical assistance. The treatment plan recommended home health, physical therapy, and psychiatric assistance during her spinal cord stimulator recovery. Authorization was requested for home health care x10 days for post-surgery stimulator placement. The 9/20/15 utilization review non-certified the request for home health care x10 days for post-surgery stimulator placement as there was no documentation that the injured worker is homebound or bedridden, or documentation of a home health evaluation outlining the specific needs/goals/expected outcomes.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Home health care x10 days (for post-surgery stimulator placement):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

**Decision rationale:** The California MTUS recommends home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis. 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. Guideline criteria have not been met. There is no evidence that the patient will be confined to home following placement of the spinal cord stimulator. There is no documentation as the specific type of home health services or frequency/duration of those services that are being recommended for this patient to establish medical necessity. Therefore, this request is not medically necessary.