

<b>Case Number:</b>	CM15-0215366		
<b>Date Assigned:</b>	11/05/2015	<b>Date of Injury:</b>	03/09/1993
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	10/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/02/2015

### 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: Minnesota, Florida

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 52 year old male, who sustained an industrial injury on 03-09-1993. The injured worker was diagnosed as having lumbar post laminectomy, unspecified myalgia and myositis and lumbar or lumbosacral disc degeneration. On medical records dated 07-28-2015 and 09-29-2015 the subjective complaints were noted as chronic pain in his lumbar spine. Objective findings were noted as range of motion of lumbar spine no lumbar range of motion due to fusion; on palpation of the paravertebral muscles, spasm, tenderness and trigger point was noted. Spinous process was tender to palpation. FABERE test was positive on the right, pelvic compression test was positive and tenderness to palpation was noted on right sacroiliac joint. Treatment to date included home exercise program, medication and cervical epidural steroid injection was noted. The injured worker underwent a cervical epidural steroid injection on 10-19-2015. Current medications were listed as Amitriptyline HCL, Baclofen, Lidoderm, Valium, Vicodin, Flomax and Opana. The Utilization Review (UR) was dated 10-22-2015. A Request for Authorization was submitted. The UR submitted for this medical review indicated that the request for home care nurse of the day procedure is scheduled was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home care nurse of the day procedure is scheduled:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Home health services.

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

**Decision rationale:** California MTUS chronic pain guidelines indicate home health care is 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 injured worker is scheduled for an epidural steroid injection in the cervical spine. There is no indication that he is homebound or unable to ambulate. As such, the request for home healthcare on the day of the procedure is not supported and the medical necessity of the request has not been substantiated. The request is not medically necessary.