

Case Number:	CM14-0116740		
Date Assigned:	08/06/2014	Date of Injury:	03/18/1997
Decision Date:	10/10/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	07/25/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

The patient is a 62-year-old female who has submitted a claim for cervical spondylosis, major depression, anxiety disorder, chronic debilitating injury with CS ASIA D quadriplegia, memory deficit, neurogenic bowel and bladder, Brown-Sequard syndrome, and headache associated with an industrial injury date of 3/18/1997. Medical records from 2012 to 2014 were reviewed. The patient utilized a walker for ambulation. She stated that her mood was improving and her anxiety was decreasing. The patient previously received home health care 4 hours per day x 7 days per week. The last day that she received home care was 5/22/2014. Weekly log sheet as completed by the patient's caregiver showed that patient was assisted in grooming, exercising, meal preparation, and cleaning the house. The patient stayed in bed all the time. Nobody was available to shop for her. The patient complained of neck pain, aggravated by movement. Pain severity was rated 6 to 8/10 with intake of medications. The patient likewise had pain at the right leg, aggravated by cold weather. Physical examination of the cervical spine showed tenderness and restricted range of motion. Motor strength of right upper and lower extremities was rated 5 minus/5, while 4+/5 contralaterally. Straight leg raise test was negative. Treatment to date has included aqua therapy, and medications such as Xanax, Opana, Ambien, Percocet, Abilify, Gabapentin, Topamax, Celebrex (since November 2013), Provigil, Senna, and Zanaflex. Utilization review from 7/16/2014 denied the Prospective Request for home health care for four hours a day for seven days a week into home health care for four hours a day for seven days a week x 4 weeks because the records documented homebound status of the patient and her limited ability to ambulate.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective Request for home health care for four hours a day for seven days a 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: As stated on page 51 of California MTUS Chronic Pain Medical Treatment Guidelines, home health services are only recommended for otherwise recommended medical treatment for patients who are homebound, 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, patient's diagnoses include cervical spondylosis, major depression, anxiety disorder, chronic debilitating injury with CS ASIA D quadriparesis, memory deficit, neurogenic bowel and bladder, and Brown-Sequard syndrome. Patient utilized a walker for ambulation. She previously received home health care 4 hours per day x 7 days per week, with the last visit on 5/22/2014. Weekly log sheet as completed by the patient's caregiver showed that patient was assisted in grooming, exercising, meal preparation, and cleaning the house. The patient stayed in bed all the time. Nobody was available to shop for her. Physical examination of the cervical spine showed tenderness and restricted range of motion. Motor strength of right upper and lower extremities was rated 5 minus/5, while 4+/5 contralaterally. Given the available information, it was unclear why patient cannot perform activities of daily living when there were no significant physical impairments and functional limitations presented. Moreover, there was no comprehensive discussion as to why extension of home health services should be provided. The guideline clearly states that home health services should not include personal care and homemaker services. Her previous caregiver assisted her in grooming and cleaning the house. There was no clear indication in the medical records provided that the patient has a need of professional nursing services for the purposes of home health. Guideline criteria were not met. Therefore, the request for home health care for four hours a day for seven days a week is not medically necessary.