

Case Number:	CM14-0116944		
Date Assigned:	08/06/2014	Date of Injury:	06/03/2002
Decision Date:	09/29/2014	UR Denial Date:	07/07/2014
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 Emergency Medicine and is licensed to practice in Texas. 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 mechanism of injury was not submitted in review. The injured worker has diagnoses of major depressive disorder and pain disorder, complex regional pain syndrome of the right upper extremity, chronic neck and low back pain, multidisc protrusions of the lumbar spine, lumbar spinal stenosis, degenerative disease of lumbar spine, lumbar spondylosis and radiculopathy, depression and myofascial pain. Past medical treatment consists of physical therapy and medication therapy. Medications include Norco, Lyrica, Zanaflex and Docusate. Based on the submitted reports, the injured worker underwent left carpal tunnel release with Guyon's tunnel release, trigger thumb release, and long trigger finger release on 03/01/2005 and right carpal tunnel release and long finger release on 08/16/2005. On 07/24/2014, the injured worker complained of bilateral head pain. The physical examination revealed that the pain was a 3/10 to 6/10 with medication and 10/10 without. The physical examination lacked any evidence of range of motion, motor strength or sensory deficits. The treatment plan is for the injured worker to have a home health care provider for 4 hours a week for 1 year. The rationale and request for authorization form were not submitted in review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health care 4 hours per week for 1 year: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines HOME HEALTH SERVICES Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: The request for home health care 4 hours per week for 1 year is not medically necessary. The California MTUS Guidelines state home health services are recommended only for patients who are homebound and who are in need of part-time or intermittent medical treatment of up to 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning and laundry and personal care giving by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. The submitted report indicated that the injured worker with medication was able to do light housework, shop and cook. It also states that the injured worker takes her medication as directed decreasing her pain and improving her function. Given the above, the injured worker is not within the MTUS Guidelines. As such, the request for home health care for 4 hours per week for 1 year is not medically necessary.