

<b>Case Number:</b>	CM14-0083578		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	05/30/2000
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in California. 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 injured worker is a 71-year-old female who reported an injury on 05/30/2000. The mechanism of injury was not provided. Diagnoses included bilateral lower extremity radiculopathy, L1-2 and L2-3 adjacent segment degeneration with facet arthropathy, L3-4 stenosis, bilateral SI joint dysfunction, and status post right hip surgery. Previous treatments included home services, medications, and surgery. Diagnostic studies were not provided. Surgical history included right hip surgery. On 06/10/2014, the patient was seen for follow-up evaluation. The patient had undergone fusion; however, there had not been any fusion at the requested levels. She had proceeded with diagnostic block which essentially resolved her pain by 100% for 1 to 2 days. She performed heat therapy for flare ups and ice therapy when the weather is hot to soothe her symptoms. She complained of neck pain which extends to her upper back. Pain scale is 7.5/10. She complained of ongoing mid to low back pain with radiation into the bilateral lower extremities to feet, 7.5/10. She had difficulty sleeping secondary to ongoing pain. Upon examination, there was tenderness to the lumbar paravertebral muscles. Sensory was decreased over L3, L4, L5 and S1 dermatome distribution. Range of motion revealed flexion at 28 degrees, extension at -8 degrees, lateral bend left and right at 18 degrees. Straight leg raise was positive bilaterally. On 07/09/2014, the patient was seen for follow-up evaluation. Her pain had worsened. She rated her pain at 9/10 to 10/10. Her medications included Ambien 10 mg, meloxicam 7.5 mg, Neurontin 800 mg, Norco 10/325 mg, and Robaxin 750 mg. The injured worker had prior diagnostic facet blocks from the L1-3 levels which completely resolved her symptoms temporarily. Due to the injured worker's low functional status and inability to complete activities of daily living such as grocery shopping and cleaning her home. She lives alone and does not have a support group. The request is for pain management - radiofrequency ablation L1-L3, secondary treating physician's initial consult, and home care four hours a day,

twice per week for 4 weeks. The rationales have been provided above the date for request for authorization on 06/10/2014 and 07/09/2014.

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

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

**Home care four hours a day, twice per week for 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CMS 2004 Page(s): 51.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines HOME CARE Page(s): 51. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, HOME HEALTH SERVICES

**Decision rationale:** The request for home care four hours a day, twice per week for 4 weeks is non-certified. The injured worker has a history of shoulder pain. The California MTUS Guidelines state home care is recommended only for medical treatment for patients who are homebound on a part time or intermittent basis up to 35 hours per week. The medical treatment does not include services like shopping, cleaning and laundry and personal care given by home health aides like bathing, dressing, and using the bathroom. The request for home health aide was to assist the patient with ADLs. This is not recommended by the guidelines. As such, the request is non-certified.