

Case Number:	CM15-0137378		
Date Assigned:	07/27/2015	Date of Injury:	09/07/1993
Decision Date:	12/09/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	07/15/2015

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: California, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 is a 54-year-old female who sustained a work-related injury on 9-7-93. On 5-4-15, the injured worker was being treated for lumbar radiculopathy, lumbar degenerative disc disease, lumbar facet arthropathy, failed back surgery syndrome, myofascial pain syndrome and chronic pain. She rated her pain a 1 on a 10-point scale to a 5 on a 10-point scale (no change from her previous evaluation) and noted that heat, rest, lying down, quiet, medications and massage relieved her pain. Her medication regimen included Ultram 50 mg, Lidoderm 5% patch, Methocarbamol 500 mg, Prialt 100 mg, Fentanyl citrate 0.05 mg-ml and Ibuprofen 800 mg. Objective findings included tenderness to palpation over the lumbar L5-S1 and pain across her back on extension and along the facet joints. Her lumbar range of motion included forward flexion to 100 degrees and hyperextension to 10 degrees. She had a positive bilateral straight leg raise. She exhibited an antalgic gait and had bilateral spasm of the lumbar spine. She continued conservative treatment including a home exercise program, moist heat and stretches. Her intrathecal pump was analyzed and was working properly. The evaluating physician noted that the injured worker was obtaining functional pain control to the lower back, hips, and legs with her intrathecal pain pump and her current medications. Due to her disability and to minimize significant flare ups of pain causing further pain pump and using tramadol for breath through pain, the evaluating physician noted assistance in maintaining her home via a housekeeper was appropriate. A request for housekeeping and a follow-up visit was received on 6-8-15. On 6-15-15, the Utilization Review physician determined housekeeping and a follow-up visit was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Housekeeping: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS 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 section, Home health services.

Decision rationale: Pursuant to the Official Disability Guidelines, housekeeping is not medically necessary. Home health services are recommended on a short-term basis following major surgical procedures or inpatient hospitalization to prevent hospitalization or to provide longer-term in-home medical care and domestic care services for those whose condition that would otherwise require inpatient care. Home health services include both medical and nonmedical services deemed to be medically necessary for patients who are confined to the home (homebound) and to require one or all of the following: skilled care by a licensed medical professional; and or personal care services for tasks and assistance with activities of daily living that do not require skilled medical professionals such as bowel and bladder care, feeding you get the benefit me out of that could be anything and bathing; and or domestic care services such as shopping, cleaning and laundry. Justification for medical necessity requires documentation for home health services. Documentation includes, but is not limited to, the medical condition with objective deficits and specific activities precluded by deficits; expected kinds of services required for an estimate of duration and frequency; the level of expertise and professional qualification; etc. In this case, the injured worker's working diagnoses are lumbar radiculopathy; degenerated disc disease lumbar; lumbar facet arthropathy; failed back surgery syndrome; myofascial pain syndrome; chronic pain; depressive disorder moderate; and anxiety disorder. Date of injury is September 7, 1993. Request for authorization is June 8, 2015. The documentation indicates psychiatric progress notes in the medical record range from July 15, 2015 through August 26, 2015 (after the request for authorization date June 8, 2015). According to the May 5, 2015 progress note, the injured worker's subjective complaints are low back and psych complaints. There are no specifics regarding anxiety and depression in the record. The injured worker uses a pain pump with fentanyl and Prialt. Objectively, the injured worker's gait is antalgic with weakness. There is tenderness to palpation L5 - S1. There is positive straight leg raising in the supine position. Sensory examination is intact and motor examination is grossly normal. Medications include Ultram, Lidoderm patch, methocarbamol, prialt (IT), fentanyl (IT) and ibuprofen. There are no psychiatric medications documented in the May 2015 progress note. Home health services (both medical and nonmedical) are medically necessary when the injured worker is confined to the home. There is no documentation the injured worker is homebound. The treatment plan contains a request for follow-up care with [REDACTED] (psychiatrist). Further evaluation of the medical record according to a July 15, 2015 psychiatric progress note states the injured worker was last seen August 23, 2012. Injured worker does not follow up on a regular basis. The treatment plan states continued physical therapy. The injured

worker ambulates with a staff. Medications include Paxil 20 mg 1 PM HS. Based on the clinical information in the medical records, peer-reviewed evidence-based guidelines, documentation indicating the injured worker ambulates with a staff and no documentation the injured worker is homebound, housekeeping is not medically necessary.

Follow-Up Visit: Upheld

Claims Administrator guideline: Decision based on MTUS Stress-Related Conditions 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Follow-up visits.

Decision rationale: Pursuant to the Official Disability Guidelines, follow-up visit is not medically necessary. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines as opiates or certain antibiotics require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Determination of necessity for an office visit requires individual case review and reassessment being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. In this case, disc disease lumbar; lumbar facet arthropathy; failed back surgery syndrome; myofascial pain syndrome; chronic pain; depressive disorder moderate; and anxiety disorder. Date of injury is September 7, 1993. Request for authorization is June 8, 2015. The documentation indicates psychiatric progress notes in the medical record range from July 15, 2015 through August 26, 2015 (after the request for authorization date June 8, 2015). According to the May 5, 2015 progress note, the injured worker's subjective complaints are low back and psych complaints. There are no specifics regarding anxiety and depression in the record. The injured worker uses a pain pump with fentanyl and Prialt. Objectively, the injured worker's gait is antalgic with weakness. There is tenderness to palpation L5 - S1. There is positive straight leg raising in the supine position. Sensory examination is intact and motor examination is grossly normal. Medications include Ultram, Lidoderm patch, methocarbamol, prialt (IT), fentanyl (IT) and ibuprofen. There are no psychiatric medications documented in the May 2015 progress note. Home health services (both medical and nonmedical) are medically necessary when the injured worker is confined to the home. There is no documentation the injured worker is homebound. The treatment plan contains a request for follow-up care with [REDACTED] (psychiatrist). Further evaluation of the medical record according to a July 15, 2015 psychiatric progress note states the injured worker was last seen August 23, 2012. Injured worker does not follow up on a regular basis. The treatment plan states continued physical therapy. The injured worker ambulates with a staff. Medications include Paxil 20 mg 1 PM HS. As noted above, the treatment plan contains a request for follow-up with the psychiatrist. The frequency for follow-up is not specified in the medical record. The last follow-up visit with the psychiatrist was approximately 3 years prior. There is no regular follow-up documented. There is no clinical rationale for psychiatric follow-up visit. The injured worker takes a single psychiatric medication (Paxil 20 mg HS). Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation indicating the frequency for follow-up and no clinical rationale for a follow-up visit based on medications taken and prior psychiatric follow-up, follow-up visit is not medically necessary.