

Case Number:	CM13-0023590		
Date Assigned:	11/15/2013	Date of Injury:	09/16/2010
Decision Date:	03/27/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	09/13/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 physician 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:

This is a male patient with a date of injury of 9/16/10. A utilization review determination dated 9/9/13 recommends non-certification of home health care 2 hours/day x 5 days/week x 6 weeks and physical therapy 2 x 6. A progress report dated 7/26/13 identifies subjective complaints including, "right shoulder/right upper extremity - substantial difficulty with activities of daily living." Objective examination findings identify, "right shoulder/right upper extremity reveals deformity. There is atrophy and history of polio. There is grade 3/5 muscle weakness of the right upper extremity in all planes. Range of motion is decreased in all planes. Examination of the right elbow is unchanged." Diagnoses stated on September 16, 2010, "status post right mid shaft humerus fracture with marked angulation deformity; right shoulder contusion/sprain; right elbow contusion/sprain/history of hairline fracture; psychiatric complaints, deferred to [REDACTED]." Treatment plan recommends, "occupational therapy...12 sessions, with goals of increasing functional activities of daily living to the right shoulder/right arm. Request new location closer to home and change to physical therapy/rehabilitation, home care assistance at a frequency of two hours per day, five days per week for six weeks."

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health care 2 hours/day times 5 days/week times 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Home health Services Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Home health Services Page(s): 51. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

Decision rationale: Regarding the request for home health care, California MTUS states that home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, and 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. Within the documentation available for review, there is no documentation that the patient is homebound and in need of specialized home care (such as skilled nursing care, physical, occupational, or speech-language therapy) in addition to home health care. In the absence of such documentation, the currently requested home health care is not medically necessary.

physical therapy 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter on Pain, Suffering, and Restoration of Function, pae 114; Official Disability Guidelines (ODG) Shoulder Chapter and Physical Therapy Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Physical Medicine Page(s): 98-99.

Decision rationale: Regarding the request for physical therapy, California MTUS states that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Within the documentation available for review, there is generalized 3/5 muscle weakness and decreased range of motion of the right upper extremity in all planes. However, there is no documentation of objective improvement with any previous physical therapy and that the nonspecific strength and ROM deficits cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested physical therapy is not medically necessary.