

Case Number:	CM13-0027491		
Date Assigned:	11/22/2013	Date of Injury:	02/07/2004
Decision Date:	07/25/2014	UR Denial Date:	09/16/2013
Priority:	Standard	Application Received:	09/20/2013

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 & 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 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:

The patient is a 55 year old male who was injured on 02/07/2004. The mechanism of injury is unknown. The patient underwent a right rotator cuff repair in 2008; and a left rotator cuff repair in 2005/2007. Pain management note dated 08/01/2013 states the patient complained of bilateral trapezius shoulder pain radiating down into bilateral upper extremity to the medial/lateral aspects of the elbow. She rates her pain as 10/10. She describes it as sharp in nature, burning with intermittent stabbing pain. Objective findings revealed an antalgic gait. Neck lateral flexion to 45 bilaterally; rotation to 90 bilaterally. The shoulder reveals flexion rotation to 90 degrees on the right and 80 degrees on the left. There is positive impingement test bilaterally. Shoulder internal rotation on the right is 70 and on the left is 50; external rotation on the right is 70 and on the left is 45 degrees. Assessment and plan is cervical spondylosis without myelopathy and spinal stenosis in the cervical region. The patient was prescribed Percocet 10/325, Duragesic patch 50 mcg and requests for refills for Valium 10 mg and urine drug screen. There were no diagnostic studies for review. Prior utilization review dated 09/16/2013 states the request for one home health aide, 40 hours per week for 12 weeks is non-certified as there is a lack of documented evidence to support the request. Medical records indicate that the patient is unable to get a full night's rest and has hard time dealing at home, thus needing home aid.

IMR ISSUES, DECISIONS AND RATIONALES

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

One Home Health Aide, 40 Hours per Week for 12 Weeks: Upheld

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

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

Decision rationale: According to the guidelines, home health services are only indicated for otherwise recommended medical treatment for patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. The medical records do not establish a clinical rationale for these requested services. Prior utilization review dated 09/16/2013 states medical records indicate that the injured worker is unable to get a full night's rest and has a hard time dealing at home, thus needing home aide. The medical records do not establish the injured worker meets the criteria to warrant consideration for home health care services.