

Case Number:	CM13-0039518		
Date Assigned:	02/14/2014	Date of Injury:	05/22/2011
Decision Date:	08/08/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/07/2013

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 Occupational Medicine 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:

This is a 61-year-old female with a 5/22/11 date of injury. Medical records from 2013 and 2014 were reviewed, indicating a history of depression, pain complaints to include neck pain, mid and low back pain, bilateral shoulder pain, bilateral thumb pain, and difficulty sleeping. A 9/18/13 progress report indicates that the patient was considered for left shoulder arthroscopic rotator cuff repair. Once the surgery has been performed, the patient will be limited in her ability to perform certain activities; and she may require subsequent right shoulder surgery. Following surgery, the patient will have difficulty performing household course such as cooking, grooming, bathing and dressing. The patient lives alone and has no one who would be able to help her. Treatment to date has included psychotherapy, medication, biofeedback, wrist brace, and activity modification. There is documentation of a previous 9/30/13 adverse determination because the patient was not considered in need of home medical treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME ASSISTANCE ADLs: Upheld

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

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

Decision rationale: MTUS Guidelines state that home health services are recommended only 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. However, there is no evidence that the patient is homebound or would require medical care rendered in a home setting. 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. Therefore, the request is not medically necessary.