

Case Number:	CM14-0001455		
Date Assigned:	01/22/2014	Date of Injury:	09/19/2000
Decision Date:	05/07/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	01/03/2014

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 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:

Medical reports from 2012 to 2013 were reviewed and indicate persistence of bilateral wrist and forearm complaints. The patient was diagnosed with right-sided thoracic outlet syndrome post first rib removal, cervical degenerative disk disease, lumbar degenerative disk disease, bilateral shoulder impingement with left frozen shoulder, diffuse regional mild fascial pain and chronic pain syndrome with both sleep and mood disorder. The patient previously underwent bilateral carpal tunnel releases, cubital tunnel, and radial tunnel releases. Treatment to date has included physical therapy, paraffin baths, medication, trigger point injections, and activity modification. The patient has also had psychiatric care. The most recent progress reports indicate persistent left shoulder, neck, arm and wrist pain. The patient continued to have left upper extremity pain and difficulty mobilizing the extremity. There was consideration for functional restoration program participation. There is documentation of a previous 11/22/13 adverse determination because the patient is ambulating with a walker.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME HEALTH ASSISTANCE 2 HOURS A DAY X 3 DAYS PER WEEK: 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 Page(s): 51.

Decision rationale: The MTUS Chronic Pain 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. The request as submitted is open-ended and would exceed medical practice standards of care. Therefore, the request is not medically necessary and appropriate.