

<b>Case Number:</b>	CM14-0015561		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	07/13/2011
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	01/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2014

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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:

The injured worker is a 37 year old male who reportedly was injured on 07/13/11. He was pushing a heavy barrel and had onset of pain to the neck, right shoulder, upper, and low back. Records reflected that the injured worker was status post microdecompression at L5-S1 on the right side, but the date of surgical intervention was not reported. Per progress report dated 12/02/13 the injured worker presented with complaints of chronic pain to the right shoulder and residual pain to the lumbar spine. Regarding lumbar spine overall his condition was improving. He was previously approved for right shoulder surgery. Per progress report dated 12/27/13 the injured worker continued to complain of pain in the right shoulder. He had difficulty with activities of daily living and difficulty with lifting, pushing, pulling, overhead, and over the shoulder activities. There was loss of motor strength over the right deltoid 4/5. The injured worker also complained of residual pain in the right lower extremity along with low back pain. He indicated that pain and weakness were increasing in severity. He had difficulty with daily activities and prolonged periods of sitting, standing, walking, and stair climbing and pushing, pulling, lifting, squatting, kneeling, and stooping. Request for MRI of lumbar spine and for home health care five hours per day, seven days a week times two weeks post-operative right shoulder surgery was non-certified as medically necessary on utilization review dated 01/27/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 290. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, MRI

**Decision rationale:** Per the MTUS Chronic Pain Guidelines, home health services are recommended only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis. Such treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health like bathing, dressing, and using the bathroom when this is the only care needed. Records provided do not indicate the rationale for home health services and the services to be provided. Moreover there is no documentation provided concerning the situation of the injured worker regarding a spouse or other family support at home. As such, medical necessity is not established for the proposed home health care.

**Home Health Care Five (5) Hours per Day, Seven (7) Days a Week Times Two (2) Weeks Post Op Right Shoulder Surgery: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** Per the MTUS Chronic Pain Guidelines, home health services are recommended only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis. Such treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health like bathing, dressing, and using the bathroom when this is the only care needed. Records provided do not indicate the rationale for home health services and the services to be provided. Moreover there is no documentation provided concerning the situation of the injured worker regarding a spouse or other family support at home. As such, medical necessity is not established for the proposed home health care.