

<b>Case Number:</b>	CM14-0128444		
<b>Date Assigned:</b>	08/25/2014	<b>Date of Injury:</b>	02/28/1997
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	07/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2014

### 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 Physical Medicine and 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 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 patient sustained an injury on 2/28/1997 while employed by [REDACTED]. Request(s) under consideration include Retrospective request for Home Health Services from March to June 2014. Diagnoses included lumbosacral spondylosis and shoulder arthropathy. Report of 2/4/14 from the provider noted the patient with ongoing chronic pain symptoms. The patient had follow-up for low back pain, status post radiofrequency ablation on 3/9/11. Complaints also included bilateral scapular pain and right neck pain. Exam showed patient is able to ambulate without assist device and can walk on her toes and heels with some difficulty. Noted was diffuse pain with limited range in cervical and lumbar spine; negative straight leg raise/ Lasegue's; negative Spurling's; deep tendon reflexes 2+ at knees; decreased sensation to alcohol swab over shin, at the L4 dermatome which is unexplained, but no motor deficit in bilateral lower extremities. Treatment included medications, MRI of cervical spine; TFESI; shoulder steroid injection. No home health was recommended. The patient has now submitted a request for reimbursement of home health services accompanying a prescription dated 6/30/14 from chiropractic office from unknown practitioner for diagnoses of cervicothoracic and right shoulder injury. There is a procedural report dated 2/27/14 noting patient had received shoulder steroid injection under fluoroscopy. The request(s) for Retrospective request for Home Health Services from March to June 2014 was non-certified on 7/17/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for Home Health Services from March to June 2014: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 21.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 52.

**Decision rationale:** MTUS and Medicare Guidelines support home health for patients who are homebound requiring intermittent skilled nursing care or home therapy and do not include homemaker services such as cleaning, laundry, and personal care. The patient does not meet any of the criteria to support this treatment request and medical necessity has not been established. Submitted reports have not adequately addressed the indication or demonstrated the necessity for home health care. The patient is not homebound, able to have multiple follow-up medical visits with variety of specialists. Report also noted no specific deficient performance issue evident or specific limitations in activities of daily living with exam findings of intact neurological motor strength, and deep tendon reflexes that would not require any formal therapy treatment. Submitted reports have not demonstrated support per guideline criteria for treatment request. As such, the request is not medically necessary.