

Case Number:	CM14-0078044		
Date Assigned:	07/18/2014	Date of Injury:	10/30/2010
Decision Date:	09/08/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/27/2014

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 Orthopaedic Surgery 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 41-year-old female accountant sustained an industrial injury on 10/30/10, due to cumulative trauma. The 7/1/11 lumbar MRI impression documented L4/5 and L5/S1 disc bulges with bilateral neuroforaminal stenosis. The 11/7/13 bilateral L4/5 transforaminal epidural steroid injection provided relief of leg pain but only slight relief of back pain. The 6/3/13 right shoulder MRI documented moderate, focal distal supraspinatus tendinopathy with associated subdeltoid bursitis. The patient underwent right shoulder arthroscopic subacromial decompression, distal clavicle resection, and labral cuff debridement on 12/4/13. The patient completed 24 post-op physical therapy visits with increased mobility and function. The 3/14/14 treating physician report indicated the patient had grade 3-4/10 low back and right shoulder pain with medications and 8/10 pain without medications. She was able to perform activities of daily living and had improved participation in home exercise. Review of systems was positive for fatigue, joint pain, muscle spasms, sore muscles, numbness, depression, stress, anxiety, mood swings, difficulty sleeping, headaches, dizziness, memory loss and concentration difficulties. The patient was to continue home exercise and home electrical stimulation. She was prescribed Norco and Lidoderm. Home care was requested for cleaning, laundry, cooking, and grocery shopping. The 5/6/14 utilization review denied the request for home care services as there was no documentation of medical problems that would warrant the need for requested services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Care 2hrs/day, 3x/week x 6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health care Page(s): 51. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Medicare Benefits Manual (Rev. 144, 05-06-11), Chapter 7 - Home Health Services; section 50.2 (Home Health Aide Services).

Decision rationale: The California MTUS recommends home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, and laundry when this is the only care needed. Medicare provides specific patient selection criteria for in home services, including the individual is confined to the home and the service must be prescribed and periodically reviewed by the attending physician. Additionally, the individual must be in need of skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology; or have a continuing need for occupational therapy. Guideline criteria have not been met. There is no evidence that the patient is homebound. There is no evidence or physician recommendation evidencing the need for intermittent skilled nursing care or physical therapy in the home environment. Therefore, this request is not medically necessary.