

<b>Case Number:</b>	CM14-0206445		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	09/30/2012
<b>Decision Date:</b>	02/12/2015	<b>UR Denial Date:</b>	11/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2014

### 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 Rehabilitation, has a subspecialty in Interventional spine 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:

The patient is a 62-year-old male with an injury date of 09/30/2012. Based on the 09/29/2014 progress report, the patient complains having constant right shoulder pain, which he rates as a 7/10 while resting and an 8/10 with activities. His pain is associated with weakness. "He is unable to perform his activities of daily living due to this pain." The 10/30/2014 report indicates that the patient has a burning right shoulder pain radiating down the arm to the fingers associated with muscle spasms. He rates his pain as a 7/10 and describes it as being constant, moderate to severe. In regards to right shoulder, there is +3 tenderness to palpation at the supraspinatus tendon attachment sites and palpable +2 tenderness at the supraspinatus and infraspinatus muscles. The patient has decreased range of motion, decreased grip strength on the right compared to the unaffected left, positive Neer's impingement sign, positive Kennedy-Hawkins, and a positive Jobe's test. The 11/07/2014 report states that the patient continues to have shoulder pain and a limited range of motion. No further exam findings were provided on this report. The patient's diagnoses include the following: 1. Injury of supraspinatus, infraspinatus, and subscapularis tendons of the rotator cuff of right shoulder, per MRI dated 01/29/2014. 2. Superior glenoid labrum lesion of the right shoulder (SLAP tear), per MRI dated 01/29/2014. 3. Anterior and posterior level tears, right shoulder, per MRI dated 01/29/2014. 4. Bicipital tendinitis of right shoulder, per MRI dated 01/29/2014. 5. Posttraumatic osteoarthritis, AC and GH joint, right shoulder, per MRI dated 01/29/2014. The utilization review determination being challenged is dated 11/10/2014. There were treatment reports provided from 05/29/2014 - 11/10/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home Health Care:** 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 service Page(s): 51.

**Decision rationale:** The patient presents with burning right shoulder pain, which radiates down the arm to the fingers and is associated with muscle spasms. The request is for HOME HEALTH CARE. The patient has a decreased range of motion, decreased grip strength on the right compared to the unaffected left, positive Neer's impingement sign, positive Kennedy-Hawkins, and a positive Jobe's test. MTUS Guidelines page 51 has the following regarding home service, "Recommended only for otherwise recommended medical treatment for patients who are home-bound on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include home maker 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 10/27/2014 report indicates that the patient currently lives alone, and the treater is requesting for a home health care. No further discussion was provided regarding this request. In this case, MTUS Guidelines recommend generally up to no more than 35 hours per week; however, the treater does not indicate how many hours a week he is requesting home health care for. In addition, there is no documentation of paralysis, significant neurologic deficits, or functional loss to prevent this patient from self-care and performing the necessary ADLs. The patient has chronic pain mainly from the shoulders. It may be difficult but not unreasonable to do self-care and carry ADL's on own. MTUS does not support home care assistance, if this is the only care that is needed. This patient does not present with any organic basis for inability to perform home duties. The requested home health care IS NOT medically necessary.