

Case Number:	CM15-0107400		
Date Assigned:	06/11/2015	Date of Injury:	03/24/2010
Decision Date:	07/15/2015	UR Denial Date:	05/23/2015
Priority:	Standard	Application Received:	06/03/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 54 year old male, who sustained an industrial injury on 3/24/2010. He reported injuring the left side of his body in a fall. Diagnoses have included status post left calcaneal fracture with open reduction internal fixation on 4/1/2010, status post left ankle triple arthrodesis on 7/21/2012, status post left shoulder rotator cuff repair on 10/1/2010, status post left elbow radial head implant on 12/21/2010, left mild carpal tunnel syndrome and lumbar spine musculoligamentous sprain/strain with left lower extremity radiculitis. Treatment to date has included multiple surgeries and medication. According to the progress report dated 5/8/2015, the injured worker complained of low back pain with pain and altered sensation to the left leg and foot. Exam of the lumbar spine revealed paravertebral muscle guarding, left side greater than right, with asymmetric motion loss. Straight leg raise test was positive on the left, eliciting radicular symptoms to the foot. Exam of the left shoulder revealed guarding/antalgia. Impingement test was positive. Cross arm test was positive. Authorization was requested for eight weeks of continued home care assistance two hours a day seven days a week.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Weeks of Home Care Assistance, 2 Hours a Day, 7 Days a Week: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Home Health Services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

Decision rationale: This patient is status post hardware removal on 06/03/14. This patient presents with chronic low back pain. The current request is for 8 Weeks of Home Care Assistance, 2 Hours a Day, 7 Days a Week. The RFA is dated 05/08/15. Treatment to date has included multiple surgeries, physical therapy and medication. The patient is TTD. MTUS Guidelines, page 51, has the following regarding home service, "Recommended only for otherwise recommended medical treatments 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 homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." According to the progress report dated 5/8/2015, the patient complained of low back pain and decreased sensation to the left leg and foot. Examination of the lumbar spine revealed paravertebral muscle guarding, left side greater than right, with asymmetric motion loss. Straight leg raise test was positive on the left, eliciting radicular symptoms to the foot. Examination of the left shoulder revealed positive Impingement test and Cross arm. The treater made a request for "continued home care assistance." It appears that the patient was previously receiving home care assistance. Home health care nursing notes are not provided and it is unclear how long assistance was provided for. There is no documentation as to why the patient is unable to perform self-care and it does not appear the patient is home bound. Without adequate diagnostic support for the needed self-care such as loss of function of a limb or mobility, the request for home health care would not be indicated. In addition, there is no documentation found in the reports provided that the patient requires medical treatment at home. Therefore, the request IS NOT medically necessary.