

<b>Case Number:</b>	CM15-0144205		
<b>Date Assigned:</b>	08/05/2015	<b>Date of Injury:</b>	08/13/2004
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	06/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2015

### 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: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports Medicine

### 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 57 year old female with an industrial injury dated 08-13-2004. Her diagnoses included chronic regional pain syndrome I left upper extremity, status post spinal cord stimulator and capsulitis of left shoulder. Prior treatment included medications, home health, home exercise program and spinal cord stimulator. She presented on 05-27-2015 with complaints of pain in the left arm with sensitivity to the left hand. She rated the pain as 8 out of 10 without medications or her spinal cord stimulator. The provider documents the injured worker has not had prescriptions filled since 09-2014 due to non-coverage. She was using over the counter Motrin. Physical exam noted guarding of the left upper extremity. There was positive allodynia and positive hyperesthesia. Left arm was cold with tenderness to palpation of the musculature at the trapezius as well as rhomboids. Internal and external rotations were both limited to abduction above the level of the shoulder. The treatment plan included continue home health 5 hours per day, 5 days a week to assist with activities of daily living, home exercise program, medications, follow up and transportation - "patient cannot drive to and from office visits." The treatment request was for home health aide 5 hours a day, 5 days a week.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home health aide 5 hours a day, 5 days a week: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health, Page 51.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Home health care. MTUS guidelines state the following: Home health services, recommended only for otherwise recommended medical treatment for patients who are homebound, 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, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. (CMS, 2004) According to the clinical documentation provided. The patient does not meet requirement for home health. Home Health-care is not medically necessary to the patient at this time.