

Case Number:	CM14-0168712		
Date Assigned:	10/16/2014	Date of Injury:	10/30/1997
Decision Date:	11/18/2014	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	10/13/2014

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 Occupational Medicine 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:

Injured worker is a female with date of injury 10/30/1997. Per primary treating physician's progress report dated 9/5/2014, the injured worker complains of left shoulder pain, increased with lifting, pushing and pulling. Since last visit (7/23/2014) she underwent two of eight requested sessions of chiropractic treatment to the left shoulder with benefit of slight increased mobility. She states that her left shoulder pain is increasing with decreased function. She is also on home exercise program with ice application. With regard to the left knee, he complains of continued pain symptoms, which are essentially unchanged with on and off flare-ups and with weight bearing intolerance. The left knee pain is frequent and moderate at a level of 5-6/10. She states that she is under psychiatric care. Examination of the left shoulder reveals old post-operative changes as prior. Tenderness to palpation is present over the subacromial region, supraspinatus tendon, acromioclavicular joint and trapezius trigger points. Subacromial crepitus is present. Impingement test and Cross Arm test are positive. There is resistive Sacroiliac stress testing. Range of motion of the shoulder is limited and measured with flexion 149 degrees, extension 40 degrees, abduction 132 degrees, adduction 35 degrees, internal rotation 63 degrees and external rotation 73 degrees. There is grade 4/5 weakness upon flexion, abduction and external rotation. Diagnoses include 1) status post left knee contusion/sprain with severe medial compartment degenerative joint disease/spur and patellofemoral degenerative joint disease 2) status post two arthroscopic surgeries 3) status post left total knee replacement.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 weeks of home care assistance 3 hours per day, 5 days per week: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Benefits Manual (Rev. 144, 05-06-11), Chapter 7 - Home Health Services; section 50.2 (Home Health Aide Services)

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

Decision rationale: The MTUS Guidelines recommend home health services only for otherwise recommended medical 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, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. The requesting physician explains that home care assistance is for household cleaning, cooking, meal preparation, laundry and assistance with activities of daily living. This request is for homemaker services and not for medical treatment, Medical necessity has not been established within the recommendationa of the MTUS Guidelines. The request for 6 weeks of home care assistance 3 hours per day, 5 days per week is determined to not be medically necessary.