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| Case Number: | CM13-0041972 | | |
| Date Assigned: | 12/20/2013 | Date of Injury: | 10/24/1996 |
| Decision Date: | 07/28/2014 | UR Denial Date: | 10/09/2013 |
| Priority: | Standard | Application Received: | 10/16/2013 |

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 Family Practice and is licensed to practice in Georgia and Texas. 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 injured worker is a 52-year-old male with a date of injury on 10/24/1996, due to being struck by a motor vehicle. The injured worker had complaints on physical examination dated 08/16/2013 of low back pain radiating to the right lower extremity, with numbness and tingling. His primary complaint is difficulty sitting, standing, bending, and lifting. Examination of the lumbar spine reveals tenderness to palpation with moderate muscle guarding had spasm over the paravertebral musculatures. Straight leg raising test is positive on the right foot. Sensation is decreased in the right lower extremity, along the L5 and S1 nerve roots. There is grade 4/5 muscle weakness in the right lower extremity. There were no diagnostic studies submitted with the document. The injured worker's medications were Ultram 1 to 2 times per day, Ambien 5 mg once at bedtime. The treatment plan was to continue home exercise program, TENS unit, and self-guided pool program. The current diagnoses were cervical/trapezial musculoligamentous sprain/strain with bilateral upper extremity radiculitis; thoracolumbar musculoligamentous sprain/strain with bilateral lower extremity radiculitis and right sacroiliac joint sprain. The rationale and the Request for Authorization were not submitted in this document for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health assistance 3 hours per day 2 days per week on an indefinite basis: 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 Services Page(s): 51.

Decision rationale: The request for home health assistance 3 hours per day, 2 days per week on an indefinite basis is non-certified. There is no documentation of the injured worker's functional status. Pain assessment, pain relief values and/or improved functional capacity were not reported. The key outcome goals for this request were not reported. The California Medical Treatment Utilization Schedule recommends 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 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 documents submitted do not give rationale for the request of home health assistance on an indefinite basis. Diagnostic studies were not submitted with the documents. The documentation submitted for review is lacking information. Therefore, the request is not medically necessary.

Acupuncture 2 times a week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture 2 times a week for 3 weeks is non-certified. There is no rationale for the request of acupuncture. The request is also lacking information on body location for acupuncture treatment. California Medical Treatment Utilization Schedule states acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Pain assessment, pain relief values, and functional capacity were not reported. The document submitted for review is lacking information of medications tried and failed. Therefore, the request is not medically necessary.