

<b>Case Number:</b>	CM13-0063941		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	11/05/2008
<b>Decision Date:</b>	04/16/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and Pain Management and is licensed to practice in Florida. 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 physician 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 51-year-old female who reported an injury on 11/05/2008. The mechanism of injury involved heavy lifting. The patient was diagnosed as status post lumbar spine laminectomy and discectomy. The patient was seen by [REDACTED] on 09/11/2013. The patient reported constant moderate to severe, dull, achy low back pain with stiffness and radiation to bilateral lower extremities. The physical examination revealed decreased and painful range of motion with 3+ tenderness to palpation. The treatment recommendations included continuation of caregiver services four (4) days per week for eight (8) hours per day, transportation to and from doctors' appointments and physical therapy, a permanent hospital bed and mattress, continuation of home exercises, and continuation of acupuncture treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continue Home Care Giver four (4) days a week for eight (8) hours a day QTY: 10.00:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

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

**Decision rationale:** The Chronic Pain Guidelines indicate that home health services are 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 thirty-five (35) hours per week. As per the documentation submitted, the patient's physical examination only revealed decreased range of motion, with tenderness to palpation. There was no indication that this patient is homebound. The medical necessity has not been established. Therefore, the request is non-certified.

██████████ **Bed with Mattress QTY: 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 11th Edition, Web, Low Back, 2013

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Mattress Selection

**Decision rationale:** The Official Disability Guidelines do not recommend using firmness as the sole criteria for mattress selection. Mattress selection is subjective, and depends on personal preference and individual factors. As per the documentation submitted, the patient's physical examination only revealed limited range of motion and tenderness to palpation. There was no documentation of significant instability. The medical necessity for the requested service has not been established. Therefore, the request is non-certified.

**Home Exercise (unspecific frequency and duration) QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Home Exercise Kit

**Decision rationale:** The current request is non-specific and cannot be determined as medically appropriate. The frequency and duration of treatment, as well as the specific type of home exercises required was not stated in the request. Without further information, the current request is non-certified.

**Additional Acupuncture (unspecified frequency and duration) QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines indicate that acupuncture is used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes three to six (3 to 6) treatments. The patient has continuously participated in acupuncture treatment. However, there is no documentation of objective functional improvement. Additionally, the specific frequency and duration of treatment was not stated in the requested. Based on the clinical information received, the request is non-certified.

**Transportation to and from doctor and therapy appointments QTY: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CMS Guidelines, and the Official Disability Guidelines, 11th Edition, 2013, Knee and leg, Transportation

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Transportation to and from appointments

**Decision rationale:** The Official Disability Guidelines indicate that transportation to and from appointments is recommended for medically necessary transportation to appointments in the same community for patients with disabilities preventing them from self transport. As per the documentation submitted, the patient's physical examination only revealed tenderness to palpation, with limited range of motion. There is no documentation of a significant disability preventing the patient from self transport. There is also no mention of a contraindication to public transportation. Based on the clinical information received, and Official Disability Guidelines, the request is non-certified.