

Case Number:	CM14-0006687		
Date Assigned:	01/31/2014	Date of Injury:	10/30/2007
Decision Date:	06/19/2014	UR Denial Date:	01/08/2014
Priority:	Standard	Application Received:	01/08/2014

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 Physical Medicine and Rehabilitation 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:

The injured worker is a 53-year-old female who reported an injury on 10/30/2007. The injured worker underwent an anterior cervical discectomy and fusion at C4-5 with decompression on the right brachial plexus on 07/24/2013. The documentation of 12/18/2013, per the DWC Form Request for Authorization, was requesting an OrthoStim and home health assistance. The documentation of 12/18/2013 revealed the injured worker had tenderness to palpation over the surgical scar. The injured worker had tenderness to palpation over the bilateral paravertebral musculature with muscle spasm. The diagnoses included status post anterior cervical discectomy and fusion at C4-5 with decompression of the right brachial plexus on 07/24/2013 with increased symptoms subsequent to a fall of 09/23/2013. The treatment plan included transportation, an OrthoStim 4, and home health care.

IMR ISSUES, DECISIONS AND RATIONALES

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

ORTHOSTIM 4, 30 DAY RENTAL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Galvanic Stimulation, Interferential Units, and Neuromuscular Elec.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, NMES, INTERFERENTIAL CURRENT STIMULATIONS, GALVANIC STIMULATION, Page(s): 114-116, 121,118.

Decision rationale: California MTUS recommends a one month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. They do not recommend Neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its' use in chronic pain. They do not recommend Interferential Current Stimulation (ICS) as an isolated intervention. Galvanic Stimulation is not recommended. There was a lack of documented rationale for the requested service. There was a lack of documentation indicating exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for Orthostim 4, 30 day rental is not medically necessary.

HOME HEALTH CARE (4) HOURS PER DAY, (3) DAYS A WEEK FOR (6) WEEKS:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines HOME HEALTH SERVICES.

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

Decision rationale: California MTUS states home health services are recommended only for patients who are homebound and who are in need of part time or "intermittent" medical treatment of up to 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 clinical documentation submitted for review failed to indicate the type of services that would be needed for home health care. The clinical documentation failed to indicate the injured worker was home bound and had a necessity for medical treatment to support the request. Given the above, the request for home health care 4 hours per day 3 days a week for 6 weeks is not medically necessary.