

<b>Case Number:</b>	CM14-0125191		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	12/27/1991
<b>Decision Date:</b>	12/08/2014	<b>UR Denial Date:</b>	07/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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:

According to the records made available for review, this is a 62-year-old female with a 12/27/91 date of injury, and status post lumbar laminectomy. At the time (7/15/14) of request for authorization for home health 3x2 lumbar spine, percutaneous peripheral nerve stimulation lumbar spine, SAS shoes, and aqua therapy 2x6 thoracic spine and lumbar spine, there is documentation of subjective (tingling right hand into the 5th digit, pain in the upper back, lower back, right shoulder, and right foot) and objective (diminished sensation left lateral shoulder, left index and thumb) findings, current diagnoses (thoracic spine strain, lumbar spine surgery x 7, right shoulder internal derangement, and right foot surgery), and treatment to date (medications, physical therapy, psychotherapy and TENS). A 5/20/14 medical report identifies that the patient needs assistance at home with activities of daily living, and any activities that involve bending, squatting, pushing, pulling or lifting. Regarding the requested home health 3x2 lumbar spine, there is no documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and that the patient is homebound on a part-time or intermittent basis. Regarding the requested percutaneous peripheral nerve stimulation lumbar spine, there is no documentation that percutaneous electrical nerve stimulation is to be used as an adjunct to a program of evidence-based functional restoration. Regarding the requested SAS shoes, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a special shoe/orthotic device is indicated. Regarding the requested aqua therapy 2x6 thoracic spine and lumbar spine, there is no documentation that reduced weight bearing is desirable (such as extreme obesity, need for reduced weight bearing, or recommendation for reduced weight bearing).

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Home Health 3x2 Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health.

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

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and the patient is homebound on a part-time or intermittent basis, as criteria necessary to support the medical necessity of home health services. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of no more than 35 hours per week. Within the medical information available for review, there is documentation of diagnoses of thoracic spine strain, lumbar spine surgery x 7, right shoulder internal derangement, and right foot surgery. However, given documentation that the patient needs assistance at home with activities of daily living, and any activities that involve bending, squatting, pushing, pulling or lifting, there is no documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed). In addition, there is no documentation that the patient is homebound on a part-time or intermittent basis. Therefore, based on guidelines and a review of the evidence, the request for home health 3x2 lumbar spine is not medically necessary.

### **Percutaneous Peripheral Nerve Stimulation Lumbar Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Percutaneous Electrical Nerve Stimulation (PENS)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous electrical nerve stimulation (PENS) Page(s): 97.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that percutaneous electrical nerve stimulation is to be used as an adjunct to a program of evidence-based functional restoration after other non-surgical treatments (including therapeutic exercise and TENS) have been tried and failed or are judged to be unsuitable or contraindicated, as criteria necessary to support the medical necessity of percutaneous electrical nerve stimulation. Within the medical information available for review, there is documentation of diagnoses of thoracic spine strain, lumbar spine surgery x 7, right shoulder internal

derangement, and right foot surgery. In addition, there is documentation that non-surgical treatments (including therapeutic exercise and TENS) have been tried. However, there is no documentation that percutaneous electrical nerve stimulation is to be used as an adjunct to a program of evidence-based functional restoration. Therefore, based on guidelines and a review of the evidence, the request for percutaneous peripheral nerve stimulation lumbar spine is not medically necessary.

**SAS Shoes: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 370. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot, Orthotic devices

**Decision rationale:** MTUS reference to ACOEM Guidelines supports a splint or surgical shoe if needed for forefoot sprain; wide shoes for neuroma; soft, wide shoes for hallux valgus; soft, supportive shoes for plantar fasciitis; and air sole shoes for heel spur. ODG identifies documentation of plantar fasciitis or foot pain in rheumatoid arthritis, as criteria necessary to support the medical necessity of orthotic devices. Within the medical information available for review, there is documentation of diagnoses of thoracic spine strain, lumbar spine surgery x 7, right shoulder internal derangement, and right foot surgery. However, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which a special shoe/orthotic device is indicated. Therefore, based on guidelines and a review of the evidence, the request for SAS shoes is not medically necessary.

**Aqua Therapy 2x6 Thoracic Spine and Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Aquatic Therapy Page(s): 98; 22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Aquatic therapy

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that aquatic therapy is recommended where reduced weight bearing is desirable (such as extreme obesity, need for reduced weight bearing, or recommendation for reduced weight bearing). MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services (objective improvement with previous treatment). ODG identifies visits for up

to 10 visits over 8 weeks in the management of sprains and strains. Within the medical information available for review, there is documentation of diagnoses of thoracic spine strain, lumbar spine surgery x 7, right shoulder internal derangement, and right foot surgery. However, there is no documentation that reduced weight bearing is desirable (such as extreme obesity, need for reduced weight bearing, or recommendation for reduced weight bearing). Therefore, based on guidelines and a review of the evidence, the request for aqua therapy 2x6 thoracic spine and lumbar spine is not medically necessary.