

Case Number:	CM14-0154608		
Date Assigned:	09/24/2014	Date of Injury:	10/15/2011
Decision Date:	10/27/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/22/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 patient is a 53-year-old with a reported date of injury of 10/15/2011. The patient has the diagnoses of vertebral fracture nos, thoracic spinal stenosis and lumbar spinal stenosis. Past surgical history includes thoracic fusion, left hip fracture repair and placement of intrathecal infusion pump. Per the most recent progress notes provided for review by the primary treating physician dated 09/02/2014, the patient had complaints of chronic back pain and hip pain with no acute changes. The physical exam notes the patient to be moderately obese, to be in a wheel chair and atrophy of the lower extremities. The treatment plan recommendations included internal medicine consult, rheumatology consult, MRI of the thoracic spine, home health aide and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Health Aide 7 days a week, 6 hours per day for 6 months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Home Health Services

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines home health services, Page(s): 51. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) home health services,

Decision rationale: The California chronic pain medical treatment guidelines section on home health services states: Home health services: 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 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. (CMS, 2004) The ODG section on home health services states: Recommended for patients who have a documented need for specific care services. The patient is home bound and cannot ambulate steadily without assistance. The home health aide is used for bathing, changing clothes, walking and standing. The patient primarily relies on a wheel chair for ambulation. The patient is unable to stand for greater than 30 minutes without assistance. The patient reports she is incapable of toileting, transitioning in and out of the wheelchair or dressing without assistance. The patient is status post hip replacement in 7/2013. The request however is in excess of the California MTUS recommended 35 hours per week. The documentation does provide evidence of the need for home health services but does not provide evidence of why the patient would need in excess of the recommended maximum of 35 hours/week as set forth per the California MTUS. For these reasons the request is not medically necessary.

Outpatient MRI of the thoracic spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines: MRI (magnetic resonance imaging)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: - Emergence of a red flag - Physiologic evidence of tissue insult or neurologic dysfunction - Failure to progress in a strengthening program intended to avoid surgery - Clarification of the anatomy prior to an invasive procedure Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography

[CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. Table 8-7 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. In the following circumstances, an imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more:- When surgery is being considered for a specific anatomic defect- To further evaluate the possibility of potentially serious pathology, such as a tumor Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. Per the progress reports, the need for the thoracic spine is due to continued mid-thoracic pain, the fact that the patient is status post anterior and posterior fusion at T12, and that the patient is completely wheel chair bound with weakness in the bilateral lower extremities. A surgical consult on 8/25/2014 recommended a thoracic spine MRI to rule out compression at the cord and to determine canal size. However there is no documentation of the emergence of red flags, failure or progression in a strengthening program designed to avoid surgery or plan for invasive procedure. For these reasons the criteria as set forth by the ACOEM have not been met. Therefore the request is not medically necessary.