

<b>Case Number:</b>	CM14-0027990		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	04/05/2010
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	02/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2014

### 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 & Rehabilitation and is licensed to practice in California and Washington. 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 66-year-old female with a reported injury date on 04/05/2010. Her diagnoses include status post total left knee arthroplasty on 09/25/2009. The clinical note dated 12/10/2013 noted the injured worker had chronic intractable low back pain, bilateral knee pain, and was status post bilateral knee total arthroplasty. Examination reveals increased left sciatica terminating at the plantar left heel with L5 great toe pain intermittently. It was also noted the injured worker was said to be cleared by cardiologist for a planned L4-S1 posterior lumbar interbody fusion. On physical examination, it was noted there was spasms and limited painful range of motion of the lumbar spine. It was also noted that there was a positive straight leg raise bilaterally at 60 degrees. Motor strength was measured at 4/5 bilaterally and there was noted decreased sensation at L4-5 and L5-S1. Under the treatment plan, it was recommended that the injured worker receive cardiac clearance, continue TENS unit therapy, refill medications, obtain extension of a planned L5-S1 posterior lumbar interbody fusion, and request for home health assistance 4 times a week for 5 hours a day. The Request for Authorization form was not provided within the available documentation for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CARDIAC CLEARANCE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS ACOEM , Chapter 7, page 127.

**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, Office Visits.

**Decision rationale:** The Official Disability Guidelines state that the need for an office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The guidelines also state that the determination of necessity for an office visit requires individualized case review and assessment. This request remains unclear as it was documented that the injured worker was noted to have already received cardiac clearance; there would be no benefit in receiving an additional cardiac clearance examination. Therefore, the request for cardiac clearance is not medically necessary and appropriate.

**REFILL RESTORIL 30 MG # 30.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Insomnia treatment.

**Decision rationale:** The Official Disability Guidelines states that benzodiazepines are only recommended for short-term use due to risk of tolerance, dependence, and adverse events. In addition, the guidelines state that when treating insomnia pharmacologically there needs to be documentation of the specific component of insomnia being treated such as sleep onset, sleep maintenance, sleep quality, and/or next-day functioning. This request remains unclear, as there is a lack of documentation of subjective and/or objective clinical exam findings of correlating with the diagnosis of insomnia. Additionally, it remains unclear how long the injured worker has been prescribed this medication and whether the medication has provided the desired therapeutic effect. Furthermore, there is lack of documentation as to what specific component of insomnia is being treated. Therefore, the request for refill restoril 30 mg # 30. is not medically necessary.

**HHA 4 TIMES WEEK X 5 HOURS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The California MTUS Guidelines state that home health services may be recommended only for otherwise recommended medical treatment for patients who are bed-bound on a part time or intermittent basis, generally up to no more than 35 hours per week. The guidelines also state that 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. This request remains unclear, as there is a lack of rationale as to why the physician is requesting the injured worker receive home health aide services. Additionally, there is a lack of evidence that the injured worker will require specific medical treatment at home. Therefore, the request for home health services 4 times week x 5 hours is not medically necessary.