

Case Number:	CM14-0081850		
Date Assigned:	07/18/2014	Date of Injury:	09/17/2003
Decision Date:	08/26/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/03/2014

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 Illinois. 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 47-year-old who reported an injury on September 17, 2003. The mechanism of injury was not stated. The current diagnoses include lumbago, cervicgia, displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, displacement of thoracic intervertebral disc without myelopathy, lumbosacral spondylosis without myelopathy, cervical spondylosis without myelopathy, and thoracic spondylosis without myelopathy. The injured worker was evaluated on January 8, 2014. The injured worker reported severe low back pain with lower extremity radiation as well as mid back and neck pain. Physical examination revealed significant atrophy around the right shoulder girdle, chest wall, and right upper extremity; intact distal pulses; stiffness in the cervical spine with spasm; painful and limited lumbar range of motion; dysesthesia in the left lower extremity; 1+ bilateral knee and ankle reflexes; and tenderness to palpation in the lower thoracic region. Treatment recommendations at that time included a minimally invasive fusion at L5-S1. A request for authorization was then submitted for an L5-S1 axial lumbar interbody fusion with preoperative medical clearance, a lumbar brace, a cold therapy unit, home healthcare, postoperative physical therapy, and a 2 day inpatient hospital stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Health: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back; Home Healthcare.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state 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 35 hours per week. There is no indication that this injured worker will be home bound following surgery. There is also no indication that this injured worker's surgical procedure has been authorized. As such, the request for home health is not medically necessary or appropriate.

Skilled Observation for Incision Healing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back; Home Healthcare.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state 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 35 hours per week. There is no indication that this injured worker will be home bound following surgery. There is also no indication that this injured worker's surgical procedure has been authorized. As such, the request for skilled observation for incision healing is not medically necessary or appropriate.

Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Low Back; Cold Packs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Continuous Flow Cryotherapy.

Decision rationale: Official Disability Guidelines state continuous flow cryotherapy for the spine is not recommended. It is recommended as an option after shoulder surgery for up to 7 days. There is no mention of a contraindication to at home local applications of cold packs as opposed to a cold therapy unit. There is also no indication that this injured worker's surgical procedure has been authorized. Based on the clinical information received and the above

mentioned guidelines, the request for a cold therapy unit is not medically necessary or appropriate.