

<b>Case Number:</b>	CM14-0204649		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	10/09/1990
<b>Decision Date:</b>	02/05/2015	<b>UR Denial Date:</b>	11/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 Family Practice and is licensed to practice in Ohio. 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 male with a date of injury of October 9, 1990. Fell asleep while driving resulting in a motor vehicle accident which cost multiple spinal and long fractures. He has had one cervical surgery and roughly 10 lumbar surgeries. He continues to have severe low back pain radiating legs, neck pain radiating to the arms, and bowel and bladder incontinence. Functionally, it requires the use of a wheelchair, is unable to stand for any length of time, he can sit upwards of three hours, he can walk just a few steps, is unable to dress or bathe himself, and he is considered completely disabled by the agreed medical examiner in terms of ever returning to force. The physical exam reveals palpable seromas over the flanks, is unable to stand, there is moderate tenderness of the paraspinal musculature of the thoracic and lumbar spine. There is diminished cervical range of motion. There is moderate left lower extremity weakness. Lumbar range of motion testing is not possible. The agreed medical examiner felt that nine sessions of physical therapy every three months was necessary for spinal stabilization and that he would require the help of family members to assist with activities of daily living. It was also felt that the family members should be paid to do so as the injured worker's paranoia would preclude home injury or any outside help. The diagnoses include lumbar degenerative disc disease, lumbar spinal stenosis, post-traumatic stress disorder, prior cervical fusion, history of numerous back surgeries with persistent cerebrospinal fluid leak, seromas, and depression. At issue is a request for 12 weeks of home healthcare, six hours per week, occupational therapy, and a nurse case manager. These were all noncertified previously largely on the basis that further occupational therapy was unlikely to be beneficial and that the injured worker was not going to re-enter the workforce.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 weeks of Home Health Care (6 hours per week): 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), Low Back, Home Health Services

**Decision rationale:** Home health services are recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis. 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. These recommendations are consistent with Medicare Guidelines. In this instance, the submitted medical record indicates that the injured worker is in need of assistance for homemaker needs and personal care, but does not indicate what medical treatment is required at home for 6 hours a week for 12 weeks. Therefore, based on the guidelines and the medical records reviewed, home healthcare services 6 hours a week for 12 weeks is not medically necessary.

**1 Nurse Case Manager: Overturned**

**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 Case Management in Delayed Recovery Page(s): 90.

**Decision rationale:** Patients who do not recover as expected usually have several interrelated causes of delayed functional recovery. Cases of delayed functional recovery require close management rather than simple care. The occupational health clinician can act as the manager of the case or can enlist the help of a skilled case manager, who is typically an occupational health nurse or a social worker. The patient and the employer should be full parties to the development of a plan to achieve functional recovery. The patient must assess his or her own capabilities and reasons for delayed functional recovery and create or agree to a realistic stepwise plan for improvement. He or she must also agree to stop doctor-shopping and work with the coordinator of care. Ideally, the employer will agree to job modification and progressive return to duty or to retraining the patient for another job if necessary. It is important to list and proactively manage each risk for delayed recovery before the recovery trajectory extends beyond the expected duration. Chemical dependency, work problems, family disorders, and vocational issues all require separate but integrated action plans. Some of these may be system problems or behavioral disorders requiring specialized approaches that are beyond the scope of these guidelines. However, the clinician should be aware of, and avoid, enabling behaviors and practices. Contingencies, supports, and work limits are useful in working with patients who have

difficulty increasing their level of function. Time off work can be contingent on participation in treatment or with the plan. Medication and physical therapy should be time contingent, not "as needed." Regularly scheduled time-limited appointments are usually best to limit patients' emotional demands and foster their independence. Patients should be monitored for compliance with appointments. Group interventions are often useful to provide support and help with problem solving. They are often more successful than individual interactions and allow more time to be devoted in the aggregate. In this instance, the injured worker appears to have several inter-related causes of his delayed functional recovery from the purely physical to psychiatric and has challenges with the practical aspects of living day to day. Therefore, this request is medically necessary.

## **2 occupational therapy visits: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

**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, Physical therapy.

**Decision rationale:** Direction from physical and occupational therapy providers can play a role with the evidence supporting active therapy and not extensive use of passive modalities. The most effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle-strengthening exercises seem to be the most effective types of exercises for treating chronic low back pain. (Hayden, 2005) Studies also suggest benefit from early use of aggressive physical therapy ("sports medicine model"), training in exercises for home use, and a functional restoration program, including intensive physical training, occupational therapy, and psychological support. Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. In this circumstance, there is no indication that the injured worker has had recent occupational or physical therapy. The agreed medical examiner has made the case that 9 physical therapy sessions every 3 months were necessary for spinal stabilization. Per the Official Disability Guidelines (ODG), 10-12 physical therapy visits are allowed over 8 weeks for sciatica. The guidelines treat occupational and physical therapy as equivalents; therefore, this request is medically necessary.