

Case Number:	CM14-0204884		
Date Assigned:	12/17/2014	Date of Injury:	04/12/2013
Decision Date:	02/11/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	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 Orthopedic Surgery, Spine Surgery 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:

The injured worker is a 49-year-old male who reported an injury on 04/12/2013. His mechanism of injury was a slip and fall hitting the back of his head and experiencing pain in his head and neck. His diagnoses included lumbar radiculopathy, myoligamentous sprain/strain of bilateral shoulders, sprain/strain of the right hand, chronic headaches, and severe central canal stenosis at L3 to L4. Past treatments included physical therapy, and pain medication. His diagnostic studies included CT of the head, MRI of the neck and lower back on 07/30/2013, and x-rays of the cervical and lumbar spine. His surgical history included cervical spine surgery on 12/12/2013. The progress report dated 10/24/2014 indicated the patient had frequent headaches, frequent neck pain, rated 7/10 with radiation to the bilateral upper extremities with associated tension, numbness and tingling. He complained of constant low back pain rated 8/10 with radiation to the bilateral lower extremities down to the feet with numbness, tingling and weakness. He had complaints of constant bilateral shoulder pain rated 7/10 with numbness and tingling sensations. The physical exam findings indicated upper extremity motor strength is 4/5, Hoffmann's sign is negative. Examination of the lumbar spine revealed tenderness and spasms at L3-4 and L4-5. There is sciatic notch tenderness, positive straight leg raise, and tension sign, and a positive femoral stretch test. His medications included Norco 10/325 mg and ibuprofen 800 mg. His treatment plan included requesting an electromyography/nerve conduction velocity study, discussion of possible surgery to include an interlaminar laminotomy and depression of the bilateral L3-4 and L4-5. Postoperatively, the treatment plan included lumbar brace, a front wheeled walker, 1 night inpatient hospitalization, home health evaluation, and transportation to and from the facility. The rationale for the request was not included. The Request for Authorization form was also not included.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Post-op physical therapy x 24: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25-26.

Decision rationale: The California MTUS Postoperative Guidelines indicate that for intervertebral disc disorder with myelopathy, the recommendation for postsurgical treatments is up to 16 visits. The request is for 24 postoperative physical therapy visits, which exceeds the guidelines recommendation of 16 visits. In addition, the documentation submitted does not include authorization for the surgery. Therefore, without the authorization for surgery, the request for Post-op physical therapy x 24 is not medically necessary.

Associated surgical service: Home health evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

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 are recommended only for otherwise recommended medical treatment for patients who are home bound, on a part time or intermittent basis, generally up to no more than 35 hours per week. The documentation submitted for review does not give indications as to why the injured worker would need to have home health services and not be able to physically go to a physical therapy location for outpatient care. In addition, as the authorization for the interlaminar laminotomy and decompression of the bilateral L3-4 and L4-5 is not included in the documentation and has not been authorized, the request for Home health evaluation is not medically necessary.