

Case Number:	CM14-0049001		
Date Assigned:	07/07/2014	Date of Injury:	04/17/2008
Decision Date:	01/20/2015	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	04/17/2014

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, has a subspecialty in Interventional Spine 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 patient is a 52-year-old female with date of injury of 04/17/2008. The listed diagnoses from 03/13/2014 are: 1. Disk herniations at C4-C5 and C5-C6 with moderate to severe neuroforaminal narrowing. 2. Facet arthropathy of the cervical spine. 3. Status post posterior foraminotomy on the right at C4-C5 and C5-C6 on 05/24/2012. According to this report, the patient complains of neck pain with headaches and dizziness, nausea and vomiting. She has increased pain complaints in the right trapezius region with spasms. She states that her medications help relieve her pain by approximately 70% to 80%. The examination shows posterior surgical site is clean, dry, and intact with no signs of infection. She does have tenderness to palpation of the cervical spine with spasms noted. Range of motion in the cervical spine is decreased in all planes. Decreased sensation on the right C5 dermatome. Motor exam is 4+/5 for the right deltoid, bicep, internal, and external rotators. 5-/5 for right wrist extensors, wrist flexors, and grip strength. Positive Hoffmann's test bilaterally. Biceps, brachioradialis, and triceps reflexes are hyperreflexic bilaterally. The documents include 1 progress report from 03/30/2014. The utilization review denied the request on 03/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 day supply of TENS unit wires and pads: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

Decision rationale: This patient presents with neck pain, headaches, dizziness, nausea, vomiting, and right trapezius pain. The treater is requesting a 30-Day Supply of Tens Unit Wires and Pads. The MTUS Guidelines page 114 to 116 on TENS unit states that it is not recommended as a primary treatment modality but a 1-month home-based TENS trial may be considered as a non-invasive conservative option if used as an adjunct to a program of evidence-based functional restoration. The only report provided for review does not mention how the patient is utilizing the TENS unit, how often the unit was used, and what outcomes were reported in terms of pain relief and function. There is no clear documentation of medication reduction. In this case, the MTUS Guidelines recommends a 30day home-based TENS trial before a unit and its supplies can be purchased to determine its efficacy in terms of pain relief and functional improvement. The request IS NOT medically necessary.

Postoperative home health care 2 hours a day x 10 business days Monday through Friday:
Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter on Skilled Nursing Facility (SNF) Care

Decision rationale: This patient presents with neck pain, headaches, dizziness, nausea, vomiting, and right trapezius pain. The treater is requesting Postoperative Home Health Care 2 Hours a Day X10 Business Days, Monday Through Friday. The MTUS and ACOEM Guidelines are silent with regards to the request. However, ODG on skilled nursing facility care states that it is recommended if necessary after hospitalization when patients require skilled nursing or skilled rehabilitation services or both on a 24-hour basis. The criteria for skilled nursing facility care include: 1. The patient was hospitalized for at least 3 days for major or multiple trauma or major surgery. 2. Physician certifies that the patient needs assisted care for treatment of major or multiple trauma, postoperative significant functional limitations, or associated significant medical comorbidities. 3. The patient has significant new functional limitations such as inability to ambulate more than 50 feet or perform activities of daily living such as self-care, eating, or toileting. 4. Patient requires skilled nursing or skilled rehabilitation services or both on a daily basis at least 5 days per week requiring skills of technical or professional personnel such as nurse, physical therapist, and occupation or speech therapist. 5. Treatment is precluded in lower levels of care. 6. The skilled nursing facility is a Medicare-certified facility. The treater is requesting home health care stating, "The patient no longer will have family members around the house to help her with her recovery postoperatively." The treater does not discuss the patient's ability to self-care and it does not appear that the patient is needing assistance with performing

activities of daily living including mobility. It does not appear that the patient is home-bound and medical treatment does not include home maker services like shopping, cleaning, laundry, and personal care. The treating physician has not prescribed home medical treatment and the patient underwent posterior foraminotomy on the right at C4-C5 and C5-C6 on 05/24/2012. There is nothing in the records provided to give any clinical rationale as to why the patient would require home health care two years post-surgically. The request IS NOT medically necessary.