

<b>Case Number:</b>	CM15-0000200		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	04/30/1999
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 67-year-old female, who sustained an industrial injury on 4/30/99. She reported back and leg pain. Treatment to date has included chiropractic sessions, TENS unit, epidural injections x six months and oral medications. An MRI indicated L5-S3 bulging disk and L4-L5 central canal stenosis. Currently, the injured worker reports worsening back pain and was recommended to undergo a L4/S1 spinal fusion. The treating physician requested the surgery, post-operative hospital stay (unspecified), physical therapy 3x a week for 6 weeks and home health care to do dressing changes (unspecified). Exam note 10/23/14 demonstrates increasing pain in the back and right leg. Exam demonstrates flexion to 40 degrees; Extension is noted to be -10 degrees. Decreased sensation is noted over the right lateral thigh. Positive straight leg raise testing is noted at 45 degrees. On 12/3/14, Utilization Review modified a request for post-op home health to do dressing changes (unspecified) to post-op home health to do dressing changes (one week) and a request for hospital stay (unspecified) to hospital stay (three days). The UR physician cited ODG and ACOEM guidelines.

### 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 home health for dressing changes; duration unspecified:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Home health services, [www.odg-twc.com/odgtwc/neck.htm#protocol](http://www.odg-twc.com/odgtwc/neck.htm#protocol), Aetna policy bulletin, Home Health Aides

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

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 51, Home Health Services are recommended only for medical treatment in patients who are homebound on a part-time or intermittent basis. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. Home health skilled nursing is recommended for wound care or IV antibiotic administration. There is no evidence in the records from 10/23/14 that the patient is home bound or requires dressing changes. There are no other substantiating reasons why home health services are required. Therefore, determination is for non-certification.

**Associated surgical service: hospital stay; unspecified length of stay:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), [www.odg-twc.com/odgtwc/low\\_back.htm#hospitallengthofstay](http://www.odg-twc.com/odgtwc/low_back.htm#hospitallengthofstay)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low back, Length of stay

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of hospital length of stay following a cervical fusion. According to the ODG, Low back section, Hospital length of stay, a 3-day inpatient stay is recommended following an anterior lumbar fusion. As a request is for an unspecified number of days, the determination is for non-certification as not medically necessary and appropriate.