

<b>Case Number:</b>	CM15-0105273		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	04/30/2012
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: Illinois, California, Texas  
 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 43-year-old male who sustained an industrial injury on 4/20/12, relative to cumulative trauma. Past medical and surgical history was documented as negative. Conservative treatment included medications, activity modification, epidural steroid injections, back brace, home electrical stimulation unit, acupuncture, and physical therapy. The 4/14/14 lumbar spine MRI findings documented a left paracentral disc protrusion at L5/S1 that was compressing the left L5 and S1 nerve roots. Combined with facet hypertrophy this produced spinal canal narrowing, left lateral recess narrowing, and bilateral neuroforaminal narrowing. The 4/20/15 treating physician report cited constant grade 7/10 low back pain radiating into the left leg and knee, occasional left hip pain, and constant grade 5/10 left knee pain. Functional difficulty was reported in activities of daily living. Current medications included ibuprofen. Physical exam documented normal gait and abnormal heel/toe walk due to pain. There were normal deep tendon reflexes, global 4/5 left lower extremity weakness, and intact sensation. Tenderness was noted over the paraspinal muscles, lumbar spinous processes, interspinous legs, posterior superior iliac space and facet joints. Straight leg raise was positive. Facet loading was positive. There was marked loss of lumbar range of motion. The diagnosis included lumbar spine discogenic back pain, and left sided L5/S1 disc herniation with left S1 radiculopathy. The injured worker had failed conservative treatment. The treatment plan included left L5/S1 hemilaminectomy and microdiscectomy with decompression of the nerve root with associated surgical requests. These requests included an RN assessment for post-operative wound care and home aid as needed, a motorized cold therapy unit and a DVT (deep vein thrombosis) unit. The

5/8/15 utilization review certified the requests for left L5/S1 hemilaminectomy and microdiscectomy with decompression of the nerve root, internal medicine pre-op clearance, front wheeled walker, 3 in 1 commode, and back brace. The request for RN assessment for post-operative wound care and home aid as needed was modified to one visit for RN assessment for post-operative wound care and home aid. The requests for motorized cold therapy unit and a DVT unit were non-certified with no rationale documented in the available records.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**RN assessment for postoperative wound care and home aid as needed: Upheld**

**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 Home health services Page(s): 51.

**Decision rationale:** The California MTUS recommends home health services only for otherwise recommended 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. This injured worker is certified for a lumbar decompression surgery. There is no rationale provided to support the medical necessity of home health aide services for this injured worker. The 5/8/15 utilization review modified this request and allowed one visit for RN assessment of post-operative wound care and assessment of home health needs. This would allow development of a home care plan for any specific needs that this injured worker would have. There is no compelling rationale to support the medical necessity of additional certification at this time. Therefore, this request is not medically necessary.

**Motorized cold therapy unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices, but recommend at home applications of cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted

to support the medical necessity of a motorized cold therapy unit in the absence of guideline support. Therefore, this request is not medically necessary.

**DVT (deep vein thrombosis) unit:** 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) Knee and Leg: Venous Thrombosis.

**Decision rationale:** The California MTUS are silent with regard to deep vein thrombosis (DVT) prophylaxis. The Official Disability Guidelines generally recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures, such as consideration for anticoagulation therapy. Guideline criteria have not been met. There are limited DVT risk factors identified for this patient. There is no documentation that anticoagulation therapy would be contraindicated, or standard compression stockings insufficient, to warrant the use of mechanical prophylaxis. Therefore, this request is not medically necessary.