

Case Number:	CM15-0180066		
Date Assigned:	10/20/2015	Date of Injury:	07/04/2015
Decision Date:	12/08/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	09/14/2015

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: Pennsylvania, Ohio, California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 45 year old male with an industrial injury dated 07-04-2015. A review of the medical records indicates that the injured worker is undergoing treatment for blunt musculoskeletal trauma, T12 spinal fracture, and multiple lumbar transverse process fracture with associated soft tissue hematoma. According to the discharge note dated 07-07-2015, the injured worker was status post motor vehicle collision. The injured worker was initially treated and transferred to another facility and managed exclusively by trauma team. The treating physician reported that the injured worker was consulted by the neurosurgeon who reported that the injured worker did not require any neurosurgical intervention as the injured worker does not have any neuro deficits. The treating physician also reported that the injured worker was examined by physical therapy and demonstrated that he was able to walk 15 feet. Objective findings (07-07-2015) revealed full range of motion of upper and lower extremities, muscle spasm and pain, and full motor strength in upper and lower extremities. Treatment has included hospitalization (07-04-2015-07-07-2015), prescribed medications, back brace, and periodic follow up visits. Treatment plan included discharge medications follow up in two weeks, home health care request, and home physical therapy for home safety evaluation and continuation with the physical therapy at home. The injured worker was discharged with wheel chair and bedside commode. The utilization review dated 08-19-2015, non-certified the request for home physical therapy spine (lumbar, cervical, thoracic) 2x4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home physical therapy - spine (lumbar, cervical, thoracic) 2x4: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

Decision rationale: Home health services should generally be ordered for a specific reason after completing a functional assessment or home safety assessment. Consistent with this practice, California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on home health services states "Recommended only for otherwise recommended medical treatment for patients who are homebound on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home aids of bathing, dressing, and using the bathroom when this is the only care needed." The medical records in this case do not include a recent functional assessment or clarification of the nature of services desired, or confirmation that the patient is homebound; by the timeframe under review, the patient would be anticipated to have transitioned to either independent home rehabilitation or to outpatient rehabilitation. Without additional clinical information, it is not possible to support this request as medically necessary. This request is not medically necessary.