

Case Number:	CM15-0184163		
Date Assigned:	09/24/2015	Date of Injury:	10/06/2014
Decision Date:	11/06/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	09/18/2015

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: New York, Montana
 Certification(s)/Specialty: Neurological 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 female, who sustained an industrial injury on October 6, 2014. Medical records indicate that the injured worker is undergoing treatment for lumbar displacement, lumbar radiculopathy, lumbar degenerative intervertebral discs, herniated disc lumbar five-sacral one, sciatica and lumbar stenosis. The injured worker was currently not working. On (4-29-15) the injured worker complained of moderate to severe low back pain and right leg pain. The pain was rated 5 out of 10 with medication and 10 out of 10 without medication on the visual analogue scale. Examination of the lumbar spine revealed tenderness to palpation over the right sacroiliac notch. Range of motion was decreased and painful. Sensation to light touch was decreased in the right lateral foot. Reflexes were equal bilaterally. A straight leg raise test was positive on the right. Treatment and evaluation to date has included medications, radiological studies, MRI of the lumbar spine and physical therapy. A current medication list was not noted. The treating physician recommended a right laminectomy-microdiscectomy. Current requested treatments include an inpatient stay (2-3 days), motorized cold therapy (2-week rental), home nursing for dressing changes (daily for 2 weeks) and hone therapy (6 sessions, 3 times a week for 2 weeks). The Utilization Review documentation dated 9-16-15 modified the requests for an inpatient stay to one day (original request 2-3 days), motorized cold therapy one week rental (original request 2 week rental), home health nurses daily for dressing changes times 4 (original request daily for 2 weeks) and non-certified the request for home therapy 3 times a week for 2 weeks # 6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inpatient Stay (2-3 days): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Hospital Length of Stay (LOS) Guidelines: Lumbar Spine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter-Hospitalization-LOS (length of stay).

Decision rationale: The ODG indicate for a lumbar laminectomy a mean time of 3.5 days, median 2 days and best practice goal of one day. This request falls within the range stated in the guidelines. Therefore, the requested treatment of inpatient stay of 2-3 days is medically necessary and appropriate.

Motorized Cold Therapy (2-week rental): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee Chapter, Cryotherapies.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter- cold/heat packs.

Decision rationale: The ODG guidelines note that cold/heat packs are recommended as an option for acute pain of acute complaints. The guidelines do not authorize two week rental. The requested treatment: Motorized Cold Therapy (2-week rental) Is NOT medically necessary and appropriate.

Home Nursing for Dressing Changes (daily for 2-weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter- Home Health services.

Decision rationale: The ODG guidelines would recommend home health services only for those who are having medical treatment who are home bound. Documentation is not provided that this was the case for this patient. The requested Treatment: Home Nursing for Dressing Changes (daily for 2-weeks) Is NOT medically necessary and appropriate.

Home Therapy (6-sessions, 3 times a week for 2-weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ACOEM, Pain, Suffering and the Restoration of Function Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back Chapter-home health services.

Decision rationale: The ODG guidelines would recommend home health services only for those who are having medical treatment who are home bound. Documentation does not disclose what home therapy was required three times a week for two weeks. Documentation is not provided that the patient was homebound. The requested Treatment: Home Therapy (6-sessions, 3 times a week for 2-weeks) Is NOT medically necessary and appropriate.