

<b>Case Number:</b>	CM15-0204086		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	08/11/2009
<b>Decision Date:</b>	12/23/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2015

### 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: Connecticut, California, Virginia  
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 64 year old man sustained an industrial injury on 8-11-2009. Diagnoses include lumbago and lumbar radiculopathy. Treatment has included oral medications. Physician notes dated 7-28-2015 show complaints of low back pain rated 7 out of 10 with radiation to the bilateral lower extremities rated 6-7 out of 10. The physical examination shows bilateral anterior tibialis strength is 3 out of 5 and decreased sensation is noted to the bilateral feet. Recommendations include proceed with L3-S1 decompression with fusion. Transforaminal interbody fusion of L4-S1, and rods and screws placed from L3-S1 after obtaining medical clearance. Utilization Review denied requests for home health occupational therapy, physical therapy, aide, and registered nursing services 3 days per week for two months on 9-21-2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home health Occupational therapy 1hr/day, 3 days a week for 2 months Lumbar spine:**  
 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), Physical therapy guidelines Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Physical therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The MTUS Chronic Pain Management Guidelines (pg 58-59) indicate that manual therapy and manipulation are recommended as options in low back pain; in this case, the patient is post-operative and has already completed some therapy. With respect to therapeutic care, the MTUS recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement allowing for up to 18 visits over 6-8 weeks. If the case is considered a recurrence/flare-up, the guidelines similarly indicate a need to evaluate treatment success, and even in cases of post-operative recovery, evidence of functional improvement is important. The patient needs to be evaluated for functional improvement prior to the completion of many visits in order to meet the standards outlined in the guidelines. Overall, it is quite possible the patient may continue to benefit from conservative treatment with manual therapy at this time. However, early re-evaluation for efficacy of treatment/functional improvement is critical. The guidelines indicate a time to produce effect of 4-6 treatments, which provides a reasonable timeline by which to reassess the patient and ensure that education, counseling, and evaluation for functional improvement occur. In this case, the request was appropriately non-certified by utilization review as evidence for added clinical benefit prior to completion of the entire course of therapy is critical, and therefore the initial request is not medically necessary.

**Home health Aide 1hr/day, 3 days a week for 2 months Lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009, Section(s): Home health services.

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

**Decision rationale:** The MTUS Chronic Pain Management Guidelines (pg 51) indicate that home health services are only recommended for otherwise recommended medical treatments in cases of patients who are homebound, and only on an "intermittent" basis (generally up to no more than 35 hours per week). Per the guidelines, medical treatment does not include homemaker services like shopping, cleaning, laundry or personal care like bathing, dressing, and using the bathroom when this is the only care that is needed. In this case the supplied records do not provide clear indication of treatment modalities being pursued as part of a home care plan. Further clarification as to the requirements and potential benefit of home care is warranted as it appears the patient's wife lives at home. Unfortunately, activities of daily living in the absence of further medical treatment requirements in the home are specifically addressed by the MTUS guidelines as inadequate reasons for recommending home health assistance. Without a more detailed rationale to include other recommended medical treatments as a part of home care nursing, the request in this case is not medically necessary.

**Home health RN 1hr/day, 3 days a week for 2 months Lumbar spine: 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.

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

**Decision rationale:** The MTUS Chronic Pain Management Guidelines (pg 51) indicate that home health services are only recommended for otherwise recommended medical treatments in cases of patients who are homebound, and only on an "intermittent" basis (generally up to no more than 35 hours per week). Per the guidelines, medical treatment does not include homemaker services like shopping, cleaning, laundry or personal care like bathing, dressing, and using the bathroom when this is the only care that is needed. In this case, the supplied records do not provide clear indication of treatment modalities being pursued as part of a home care plan. Further clarification as to the requirements and potential benefit of home care is warranted as it appears the patient's wife lives at home. Unfortunately, activities of daily living in the absence of further medical treatment requirements in the home are specifically addressed by the MTUS guidelines as inadequate reasons for recommending home health assistance. If there are specific concerns with respect to urinary issues, etc., these should be addressed to allow for adequate assessment of medical necessity. Without a more detailed rationale to include other recommended medical treatments as a part of home care nursing, the request in this case is not medically necessary.

**Home health Physical therapy 1hr/day, 3 days a week for 2 months Lumbar spine:** 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), Physical therapy guidelines Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Physical therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The MTUS Chronic Pain Management Guidelines (pg 58-59) indicate that manual therapy and manipulation are recommended as options in low back pain; in this case, the patient is post-operative and has already completed some therapy. With respect to therapeutic care, the MTUS recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement allowing for up to 18 visits over 6-8 weeks. If the case is considered a recurrence/flare-up, the guidelines similarly indicate a need to evaluate treatment success, and even in cases of post-operative recovery, evidence of functional improvement is important. The patient needs to be evaluated for functional improvement prior to the completion of many visits in order to meet the standards outlined in the guidelines. Overall, it is quite possible the patient may continue to benefit from conservative treatment with manual therapy at this time. However, early re-evaluation for efficacy of treatment/functional improvement is critical. The guidelines indicate a time to produce effect of 4-6 treatments, which provides a reasonable timeline by which to reassess the patient and ensure that education, counseling, and evaluation for functional improvement occur. In this case, the request was appropriately non-certified by utilization review as evidence for added clinical benefit prior to completion of the entire course of therapy is critical, and therefore the initial request is not medically necessary.