

<b>Case Number:</b>	CM15-0215692		
<b>Date Assigned:</b>	11/05/2015	<b>Date of Injury:</b>	02/01/2000
<b>Decision Date:</b>	12/23/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2015

### 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: Texas, Illinois

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:

The injured worker is a 55 year old male, who sustained an industrial-work injury on 2-1-00. A review of the medical records indicates that the injured worker is undergoing treatment for other intervertebral disc degeneration of the lumbar region, lumbar radiculopathy, sciatica, and low back pain. Treatment to date has included Nonsteroidal anti-inflammatory drugs, physical therapy. Magnetic resonance imaging (MRI) of the lumbar spine dated 7-17-15 revealed multilevel disc diseases and facet hypertrophy. The physician indicates that the x-rays of the lumbar spine show mild to moderate loss of disc height L5-S1. Medical records dated 10-2-15 indicate that the injured worker complained of worsening symptoms in the low back with pain. The pain used to be on the right side and now he reports the pain is worse on the left side. The low back pain is constant. The physical exam reveals positive tenderness in the right paraspinals, lateral bending 10-20 degrees with pain, extension is 10-20 degrees with mild pain, on forward flexion the injured worker is able to reach the knees, and there is positive seated straight leg raise on the right. The physician recommended right lumbar epidural steroid injection (ESI) in the interim and lumbar surgery. The request for authorization date was 10-2-15 and requested services included Home health care times 2 weeks and DME durable medical equipment: Motorized cold therapy unit, rental 2 weeks. The original Utilization review dated 10-12-15 non-certified the request for Home health care times 2 weeks and DME durable medical equipment: Motorized cold therapy unit, rental 2 weeks as not medically necessary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Home health care times 2 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services. Decision based on Non-MTUS Citation [http://www.emedicinehealth.com/lumbar\\_laminectomy/page5\\_em.htm#after\\_the\\_procedure](http://www.emedicinehealth.com/lumbar_laminectomy/page5_em.htm#after_the_procedure).

**Decision rationale:** The injured worker sustained a work related injury on 2-1-00. The medical records provided indicate the diagnosis of other intervertebral disc degeneration of the lumbar region, lumbar radiculopathy, sciatica, and low back pain. Treatment to date has included Nonsteroidal anti-inflammatory drugs, physical therapy. The medical records provided for review do not indicate a medical necessity for Home health care times 2 weeks. The MTUS states that home health services is 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 health aides like bathing, dressing, and using the bathroom when this is the only care needed. Although the medical records indicate the injured worker will be having back surgery, there is no evidence the injured worker is homebound, or will be homebound after the surgery. Therefore, the requested treatment is not medically necessary.

**DME durable medical equipment: Motorized cold therapy unit, rental 2 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back procedure.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic) Continuous cold therapy (CCT) Shoulder (Acute & Chronic) Continuous cold therapy (CCT).

**Decision rationale:** The injured worker sustained a work related injury on 2-1-00. The medical records provided indicate the diagnosis of other intervertebral disc degeneration of the lumbar region, lumbar radiculopathy, sciatica, and low back pain. Treatment to date has included Nonsteroidal anti-inflammatory drugs, physical therapy. The medical records provided for review do not indicate a medical necessity for DME durable medical equipment: Motorized cold therapy unit, rental 2 weeks. The MTUS states that Musculoskeletal symptoms can be managed with a combination of heat or cold therapy. However, it makes no statement about duration of usage. Nevertheless, the Official Disability Guidelines recommends that cold therapy units are more effective than a standard ice pack in the postoperative period. However, the Official Disability Guidelines recommends it only for 7 days postoperative use. Therefore, the requested treatment is not medically necessary.