

Case Number:	CM14-0152799		
Date Assigned:	09/23/2014	Date of Injury:	05/27/2014
Decision Date:	05/12/2015	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/18/2014

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: California
 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 23-year-old male who reported an injury on 05/27/2014. The mechanism of injury was the injured worker stepped down from a forklift. The injured worker was noted to have a prior lumbar injury in 11/2012 after pulling a heavy container. The injured worker underwent a lumbar discectomy at L4-5 on 06/03/2014. The injured worker's prior treatment included medications, postoperative lumbar brace, home health care for 3 weeks and a short course of postoperative physical therapy. The injured worker underwent an x-ray of the lumbar spine on 07/22/2014. There was a request for authorization submitted for review dated 07/22/2014. The documentation of 07/22/2014 revealed the injured worker had difficulties with self care and physical activities as well as getting to sleep. The physical examination revealed moderate tenderness to palpation over the lumbar paravertebral musculature. The injured worker had decreased range of motion and a positive Braggard's test and straight leg raise test bilaterally, as well as a positive bowstring's test bilaterally. There was grade 2 hamstring tightness bilaterally. The injured worker had a severe sensory deficit over the bilateral L4 and L5 dermatomes. The injured worker was unable to stand on his heels due to bilateral foot drop. The injured worker was unable to perform tandem gait and had a positive Hoffman's test on the right. The injured worker had 0/5 motor strength at L4 and L5, the tibialis anterior and EHL bilaterally. The injured worker had 3/5 quadriceps strength (L3 bilaterally). The injured worker had no deep tendon reflexes in the Achilles bilaterally and had 0 patella tendon reflexes and 0 patellar reflexes on the left and -2 on the right. The injured worker had an x-ray of the lumbar spine in six views which revealed a left convexity with the apex noted at L2-3. There was a

grade 1 retrolisthesis at L2 over L3 associated with mild disc space narrowing. There was mild disc space narrowing at L5-S1. The diagnoses included status post L4-5 laminectomy microdiscectomy on 06/03/2014 with residual lower extremity motor weakness and bilateral foot drop, anxiety and depression, GERD secondary to industrial injury and prolonged medication use, sleep disorder secondary to industrial injury and bilateral knee sprain and strain. The treatment plan included an MRI, an X-force stimulator, a solar care FIR heating system, transportation to all medical visits, and a urine drug test as well as home health assistance 4 hours a day 5 days a week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post operative physical therapy twice a week for four weeks, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The California Medical Postsurgical Treatment Guidelines recommend up to 16 visits for a discectomy and laminectomy. The clinical documentation submitted for review failed to provide the documented number of sessions that were previously attended. There was a lack of documentation of objective functional benefit that was received from prior therapy and remaining objective functional deficits. Given the above and the lack of documentation, the request for Post operative physical therapy twice a week for four weeks, lumbar spine is not medically necessary.

X-force stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back: TENS (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

Decision rationale: The California Medical Treatment Utilization Schedule recommends a one month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The clinical documentation submitted for review failed to provide documentation the injured worker would utilize the unit as an adjunct to therapy. There was a lack of documentation of exceptional factors. The request as submitted failed to indicate the frequency and the body part to be treated as well as whether the unit was for rental or purchase. Given the above, the request for X-force stimulator is not medically necessary.

SolarCare Heating System: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back: Infrared therapy.

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, Infrared therapy (IR).

Decision rationale: The Official Disability Guidelines indicate that infrared therapy is not recommended above other heat therapies. There was a lack of documentation of exceptional factors to warrant nonadherence to guidelines recommendations. The request as submitted failed to indicate whether the unit was for rental or purchase and the frequency and duration of treatment. Given the above, the request for SolarCare heating system is not medically necessary.

Transportation to all medical visits: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee and leg: Transportation (to and from appointments).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Transportation (to & from appointments).

Decision rationale: The Official Disability Guidelines indicate that transportation to and from appointments is recommended for injured workers with disabilities preventing them from self transport who are age 55 or older and need a nursing home level of care. The clinical documentation submitted for review indicated the injured worker had bilateral foot drop. The injured worker is noted to be 23 years of age. There was a lack of documentation indicating the injured worker had a nursing home level of care. Additionally, there was a lack of documentation indicating the injured worker did not have a family member who could take them to all medical visits. The request as submitted failed to indicate the duration and quantity of visits being requested. Given the above, the request for transportation to all medical visits is not medically necessary.

Home health assistance for four hours a day, five days a week for four weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back: Home Health Services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: The California Medical Treatment Utilization Schedule recommends home health services for injured workers who are homebound and who are in need of part time or

“intermittent” medical treatment of up to 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. The referenced guidelines do not recommend home health aides. There was a lack of documentation and exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for Home health assistance for four hours a day, five days a week for four weeks is not medically necessary.