

Case Number:	CM15-0110458		
Date Assigned:	06/17/2015	Date of Injury:	07/15/2012
Decision Date:	07/17/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	06/08/2015

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
 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 7/15/12 when she fell while going up stairs and striking her left shoulder feeling immediate pain. She was medically evaluated and received x-rays, physical therapy and taken off work. Due to continued pain she had an MRI, was given medications, physical therapy, left shoulder injection with minimal improvement and surgery was done 1/9/13. She then developed left sided neck pain with numbness and tingling in the left hand. She had an MRI of the neck, medications, acupuncture and physical therapy. She had a prior low back injury in 2004. Currently she complains of constant pain and stiffness to her neck radiating down the left arm with numbness and tingling of the left hand. Her pain level is 4/10. Her activities of daily living are limited in the areas of self-care, stair climbing, walking, squatting, sexual activity and sleep. On physical exam of the cervical spine there was tenderness on palpation over the paraspinal region with spasms with decreased range of motion and sensation; the left shoulder exhibits tenderness with decreased range of motion. Medication is Motrin. Diagnoses include chronic left shoulder pain, status post-surgery for labral tear and impingement syndrome; musculoligamentous strain of the cervical spine bilateral upper extremity radiculopathy, left worse than right. Diagnostics include MRI of the cervical spine (11/22/14) showing disc herniation, spinal canal stenosis; electrodiagnostic study of the left upper limb and cervical paraspinal muscles (1/9/15) was normal. The progress notes dated 4/17/15 indicated ongoing pain and symptomatology and had no relief from extensive conservative care and surgical intervention is recommended to avoid

permanent injury. The progress note requests a 2-3 day hospital stay, use of bone stimulator, 24 post-operative physical therapy visits and home health care for two weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Facility- inpatient days Qty: 3: 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), Neck and Upper Back Chapter, Length of Stay.

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

Decision rationale: The ODG guidelines indicated that the best practice goal for an Anterior cervical fusion is one day hospital stay. They list the Median stay is 1 days and the mean 2.2. days. The requested treatment: Facility- inpatient days Qty: 3 is NOT medically necessary and appropriate.

DME: Bone stimulator Qty: 1: 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), Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter- Bone-growth stimulators (BGS).

Decision rationale: The ODG guidelines note that bone-growth stimulators in cervical fusions is under study. The guidelines indicate that if the patient is a smoker, has osteoporosis or other comorbidities then a rationale could be constructed for their use. Documentation does not show this is the case with the patient. The requested treatment: DME: Bone stimulator Qty: 1 is NOT medically necessary and appropriate.

Home health care (weeks) Qty: 2: Upheld

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

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

Decision rationale: The ODG guidelines do recommend home health services if the patient is homebound. They recommend the services if there is recommended medical treatment for the patient. The documentation does not provide support for either of these criteria. The requested treatment: Home health care (weeks) Qty: 2 is NOT medically necessary and appropriate.

Physical therapy Qty: 24: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter-Physical Therapy.

Decision rationale: The ODG guidelines indicate that physical therapy should allow for fading of treatment frequency. This request for therapy does not include this specific instruction. The guidelines also recommend an active self-directed home PT. This request does not include this proviso either. The requested treatment: Physical therapy Qty: 24 is NOT medically necessary and appropriate.