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| <b>Case Number:</b>   | CM13-0049726 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 06/18/2009 |
| <b>Decision Date:</b> | 05/18/2015   | <b>UR Denial Date:</b>       | 10/30/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/08/2013 |

### 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: Physical Medicine & Rehabilitation

### 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 57-year-old male who sustained an industrial injury on 06/18/09. Initial complaints and diagnoses are not available. Treatments to date include medications and physical therapy. Diagnostic studies are not addressed. Current complaints include hip pain. Current diagnoses include degenerative joint disease of the hip, neck, and wrist. In a progress note dated 10/29/13 the treating provider reports the plan of care as a total hip replacement. The requested treatments are a motorized hot/cold unit, home physical therapy, and home nursing care.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PURCHASE OF A MOTORIZED COLD THERAPY UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck chapter, Continuous-flow cryotherapy.

**Decision rationale:** The patient presents with degenerative joint disease of the hip, neck, and wrist. The request is for PURCHASE OF A MOTORIZED COLD THERAPY UNIT. The hand-written reports provided by the treater contain little information regarding the patient's condition, treatments history, medication, etc,. The utilization review letter on 10/30/13 indicates that anterior cervical disc fusion C4-7 is requested along with a cold therapy unit. The cervical fusion is performed on 12/02/14. Work statue is unknown. The MTUS and ACOEM guidelines do not discuss cold therapy units. ODG guidelines, under Neck chapter, Continuous-flow cryotherapy Topic, does not recommend cold therapy in the neck. "Recommended as an option after shoulder surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." In this case, the treater appears to request cold therapy unit as post-op aid following the cervical fusion. However, ODG guidelines does not recommend cold therapy unit for neck condition. It is recommended for knee condition only. Therefore, the request IS NOT medically necessary.

**DAILY HOME NURSING CARE FOR TWO WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines home-health services Page(s): 51.

**Decision rationale:** The patient presents with degenerative joint disease of the hip, neck, and wrist. The request is for DAILY HOME NURSING CARE FOR TWO WEEKS. The hand-written reports provided by the treater contain little information regarding the patient's condition, treatments history, medication, etc. The utilization review letter on 10/30/13 indicates that anterior cervical disc fusion C4-7 is requested along with home nurse care. The cervical fusion is performed on 12/02/14. Work statue is unknown. The MTUS Guidelines page 51 on home-health services recommend "this service for patients who are home bound 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, laundering, and personal care given by home-health aids like bathing, dressing, and using the bathroom when this is the only care needed." In this case, the treater has asked for daily home nursing care for two weeks to presumably address post-operative needs following C-spine multi-level fusion surgery from 12/2/14. However, the treater does not explain why nursing care is needed. There is no description of any complications from surgery; no wound care needs; no other medical care needs that is needed. The treater's request is neither explained nor justified. There is no guidelines support that this type of surgery require home nursing care post-operatively. The request IS NOT medically necessary.

**HOME PHYSICAL THERAPY FOR TWO WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck chapter, physical therapy.

**Decision rationale:** The patient presents with degenerative joint disease of the hip, neck, and wrist. The request is for HOME PHYSICAL THERAPY FOR TWO WEEKS. The hand-written reports provided by the treater contain little information regarding the patient's condition, treatments history, medication, etc. The utilization review letter on 10/30/13 indicates that anterior cervical disc fusion C4-7 is requested along with post-operative physical therapy. The cervical fusion is performed on 12/02/14. Work statue is unknown. ODG guidelines under Neck chapter, physical therapy Topic, allows 24 visits of physical therapy over 16 weeks following cervical fusion. "Post-surgical treatment (fusion, after graft maturity): 24 visits over 16 weeks." In this case, the treater appears to request post-operative physical therapy. The utilization review letter on 10/30/13 indicates that the patient has had physical therapy thus far. None of the reports provided, however, discuss how many sessions of therapy the patient has had or how the patient has responded to the therapy. There is no explanation as to why a home therapy is needed and why it cannot be provided on an outpatient basis. The patient has neck surgery and there is no discussion regarding any complication that compromises the patient's ability to self-transport. The request IS NOT medically necessary.