MAXIMUS Federal Services

Case Number:	CM13-0041837		
Date Assigned:	12/20/2013	Date of Injury:	11/01/2007
Decision Date:	03/25/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Management, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a male patient with a date of injury of 11/1/07. A utilization review determination dated 10/9/13 recommends non-certification of home health nursing post op x 14 days, bone growth stimulator post op, and cold therapy unit post op. This report also notes that the patient was approved for an L4-5 laminectomy and fusion. A progress report dated 12/13/13 identifies diagnoses of spondylolisthesis grade I primary, lumbar stenosis, low back pain, and lumbar intervertebral disc degeneration, and it notes that the patient is unlikely to improve with further non-operative management and operative intervention consisting of L4-5 anterior/posterior fusion with instrumentation and laminectomy is recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health nurse daily for 2 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Home Health Services Page(s): 51 OF 127.

Decision rationale: Regarding the request for a home health nurse daily for 2 weeks, the MTUS Guidelines support home health care for patients who are homebound and in need of medical treatment. Within the documentation available for review, there is no documentation that the employee is homebound and no clear rationale for home nursing care and a specific plan for what type of care will be needed have been provided. In light of the above issues, the currently requested home health nurse daily for 2 weeks is not medically necessary.

Bone growth stimulator: 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.

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, Bone growth stimulators (BGS).

Decision rationale: Regarding the request for a bone growth stimulator, the MTUS Guidelines do not address the issue. The ODG indicate that bone growth stimulation is supported in the presence of at least 1 risk factor for failed fusion: One or more previous failed spinal fusion(s); Grade III or worse spondylolisthesis; Fusion to be performed at more than one level; Current smoking habit; Diabetes, Renal disease, Alcoholism; or Significant osteoporosis which has been demonstrated on radiographs. Within the documentation available for review, there is no documentation that any of these risk factors are present. In the absence of such documentation, the currently requested bone growth stimulator is not medically necessary.

Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat packs.

Decision rationale: Regarding the request for a cold therapy unit, the MTUS and ODG Guidelines do not specifically address the issue for the low back, although ODG supports cold therapy units for up to 7 days after surgery for some other body parts. For the back, the MTUS/ACOEM and ODG recommend the use of cold packs for acute complaints. Within the documentation available for review, there is no documentation of a rationale for the use of a formal cold therapy unit rather than the application of simple cold packs at home during the initial postoperative period. In the absence of such documentation, the currently requested cold therapy unit is not medically necessary.