MAXIMUS Federal Services

Case Number:	CM13-0065116		
Date Assigned:	05/07/2014	Date of Injury:	04/07/2000
Decision Date:	07/09/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/12/2013

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. The expert reviewer is Board Certified in Occupational Medicine 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 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/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 73-year-old male with a 4/7/00 date of injury who is status post Lumbar fusion at L3/4 and L4/5 in 2008. On 11/19/13 the patient presented with decreased strength and sensation in the right foot with associated numbness on the dorsum of the right foot, as well as bilateral leg weakness with prolonged walking. Exam findings revealed limited range of motion of the L spine and lower extremities. The patient's diagnosis is lumbar spinal stenosis at L2/3 and chronic bilateral L5/S1 radiculopathy more sever on the right at L5. The recommendation was for a L2/3 decompression and laminectomy with extension of the patient's prior fusion from L3-S1 to the L2 level. Treatment t to date has included acupuncture. The requests are for post operative assisted living facility, post operative home health care and post operative physical therapy for 2-4 hrs. daily with unspecified duration. A 12/17/13 progress report stated the patient is 2 weeks out from an L2/3 laminectomy and fusion. The patient is doing well post operatively and has minimal back pain and is able to stand for longer periods of time than before. The patient is able to get up and walk around every hour or two with a front-wheeled walker and has a lumbar brace. Exam findings reveal no tenders in the lumbar spine with a well-healed incision and limited range of motion on extension otherwise normal range of motion. There were some strength deficits in the iliopsoas and quadriceps bilaterally, sensation is intact. He was seen again on 2/4/14 where the patient was ambulating with a cane and stated the weakness in his legs had improved and was noted to have already completed seven sessions of post operative physical therapy (8 were authorized). Exam findings are unchanged with the exception of improved quadriceps strength to 5/5 and psoas strength to 4+/5. Plain films were noted on this visit but no report was given. The patient denies ever being a smoker. A UR decision dated 11/27/13 denied the request for post operative assisted living and home health given there was no indication that the patient was homebound of that the pending surgery was certified. The request

for a bone growth stimulator was denied given there was no indication that surgery was medically necessary and appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

BONE GROWTH STIMULATOR TO OPTIMIZE THE LUMBAR FUSION L2-S1:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation the (ODG) Official Disability Guidelines, Neck & 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), BONE GROWTH STIMULATOR.

Decision rationale: MTUS does not address this issue. ODG criteria for bone growth stimulators may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor); (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs.The patient is a non-smoker and the request for surgery included a one-level fusion. None of the other reasons were documented to support the request by the provider. In addition, the patient was noted to be doing well 2 months out from surgery with no lower extremity neurological deficits except for psoas strength of 4+/5 which was an improvement from his exam findings 2 weeks after surgery. The patient is a non-smoker, and his prior multilevel fusion was quite successful which gives no reason to expect this one-level fusion to fail. He was noted to be ambulating with only the use of a cane as opposed to a front-wheeled walker 2 weeks out from his surgery. Plain films were noted to be taken 2 months post operatively but the results were not made available. Per the post operative progress notes, the patient appears to be healing well. The rationale for a bone growth stimulator has not been documented. Therefore, the request for a Bone Growth Stimulator to Optimize the Lumbar Fusion L2-S1 was not medically necessary.

ASSISTED LIVING-POSTOPERATIVE HOME HEALTH ASSISTANCE TO INCLUDE HOME NURSING AND HOME PHYSICAL THERAPY FOR 2-4 HOURS DAILY:
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 home health services, physical therapy Page(s): 51, 98-99. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004)

Pain, Suffering, and the Restoration of Function Chapter 6 (page 114): Official Disability Guidelines Low Back Chapter Skilled nursing facility (SNF) care.

Decision rationale: CA MTUS states that home health services are 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. ODG criteria for skilled nursing facility care include hospitalization for at least three days; admission to the SNF within 30 days of hospital discharge; a physician certifies that the patient needs SNF care; and the patient requires skilled nursing or skilled rehabilitation services, or both, on a daily basis. The patient was noted to be doing well two months post-operatively, with no lower extremity neurological deficits except for psoas strength of 4+/5, which was an improvement from his exam findings. He was noted to be ambulating with only the use of a cane two months post-operatively, as opposed to a front-wheeled walker. Per the postoperative progress notes, the patient seemed to be healing from his surgery. He was noted to be ambulatory after surgery and not bedridden. Hence, the rationale for assisted living and home health care is unclear, as the patient was not noted to be bedridden after surgery. In addition, the patient was noted to have had 7 sessions of post operative physical therapy and 1 session to go, hence the rationale for home physical therapy 2-4 hours with no duration is not supported. Therefore, the request for Assisted Living-Postoperative Home Health Assistance To Include Home Nursing And Home Physical Therapy For 2-4 Hours Daily, is not medically necessary.