

<b>Case Number:</b>	CM14-0001529		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	08/21/2011
<b>Decision Date:</b>	06/13/2014	<b>UR Denial Date:</b>	12/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/04/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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:

The injured worker is a 59 year old male who reported an injury on 08/21/2011. The injured worker had a physical evaluation on 11/27/2013 with complaints of persistent low back pain and stiffness and left leg pain and numbness. The injured worker stated pain relief with use of a TENS unit daily and pain medications. The evaluation showed decreased active range of motion of the lumbar spine in all planes with pain at all end ranges. He had a positive straight leg raise on the right, positive Kemps bilaterally, he had tenderness and guarding bilaterally in the thoracic and lumbar paraspinal region and hypoesthesia of the left L5 and S1 dermatomes. The treatment plan was for chiropractic and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SURGICAL ASSISTANT:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES: LOW BACK, SURGICAL ASSISTANT SECTION.

**Decision rationale:** The request for a surgical assistant is certified. The Official Disability

Guidelines (ODG) recommend as an option in more complex surgeries. An assistant surgeon actively assists the physician performing a surgical procedure. Reimbursement for assistant surgeon services, when reported by the same individual physician or other health care professional, is based on whether the assistant surgeon is a physician or another health care professional acting as the surgical assistant. The injured worker has been authorized for a two level lumbar fusion surgery. The CPT code for the approved surgery meets the criteria for certification. As such, the request is medically necessary and appropriate.

**PURCHASE OF AN ORTHOFIX:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, BONE GROWTH STIMULATORS (BGS), Bone Growth Stimulator Section.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES: LOW BACK CHAPTER, BONE GROWTH STIMULATOR SECTION.

**Decision rationale:** The request for Orthofix is certified. Per Official Disability Guidelines (ODG) the criteria for use of an invasive or non-invasive electrical bone growth stimulator is considered medically necessary as an adjunct to spinal fusion surgery for patients with fusion to be performed at more than one level. The injured worker has been authorized for a L4-5 and L5-S1 fusion. The criteria is met for the approved surgery. Therefore, the request for Orthofix is medically necessary and appropriate.

**HOME HEALTH SKILLED NURSING VISITS, UP TO 3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Section.

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

**Decision rationale:** The request for Home Health Skilled Nursing Visits, up to 3 is non-certified. The CA MTUS Chronic Pain Medical Treatment Guidelines recommend 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. 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 injured workers clinical evaluation fails to document the treatment level requiring a Home Health Nurse and it fails to identify the injured worker as homebound. Therefore, the request is not medically necessary or appropriate.