

Case Number:	CM14-0065930		
Date Assigned:	07/11/2014	Date of Injury:	01/30/2012
Decision Date:	08/26/2014	UR Denial Date:	05/01/2014
Priority:	Standard	Application Received:	05/09/2014

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 Preventive 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:

According to the records made available for review, this is a 40-year-old male with a 1/30/12 date of injury, and right L5-S1 disc herniation and left synovial cyst with laminectomy on 5/29/13. At the time (5/1/14) of the Decision for External Bone Growth Stimulator and Vascutherm DVT unit, there is documentation of subjective (increased back pain with intensity of 8-9/10) and objective (right L5-S1 sensory loss, diminished right heel walking, and negative straight leg raising test) findings, current diagnoses (postoperative epidural scarring with persistent right lower extremity radiculopathy, axial low back pain out of proportion to leg pain with interspace collapse and Modic changes, and Grade 1 unstable anterolisthesis and spondylolisthesis), and treatment to date (medications and physical therapy). Medical report identifies a L4-L5 and L5-S1 fusion surgery that has been authorized/certified. Regarding Vascutherm unit, there is no documentation that the patient is at a high risk of developing venous thrombosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

External Bone Growth Stimulator: 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 (ODG) Low Back Chapter, Bone growth stimulators (BGS).

Decision rationale: MTUS does not address this issue. ODG identifies documentation of either invasive or noninvasive methods of electrical bone growth stimulation as an adjunct to spinal fusion surgery for patients with any of the following risk factors 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), as criteria necessary to support the medical necessity of bone stimulation. Within the medical information available for review, there is documentation of diagnoses of postoperative epidural scarring with persistent right lower extremity radiculopathy, axial low back pain out of proportion to leg pain with interspace collapse and Modic changes, and Grade 1 unstable anterolisthesis and spondylolisthesis. In addition, given documentation of a L4-L5 and L5-S1 fusion surgery, there is documentation of a risk factor for failed fusion (Fusion to be performed at more than one level). Therefore, based on guidelines and a review of the evidence, the request for External Bone Growth Stimulator is medically necessary.

Vascutherm DVT unit: Upheld

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 (ODG) Shoulder, Polar care (cold therapy unit); Venous thrombosis(<http://www.sosmedical.net/products/featured-products/vascutherm/>).

Decision rationale: An online source identifies Vascutherm as a device that provides heat/cold compression and DVT prophylaxis therapy. MTUS does not address this issue. ODG identifies that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use. In addition, ODG identifies documentation of subjects who are at a high risk of developing venous thrombosis, as criteria necessary to support the medical necessity of DVT prevention system. Within the medical information available for review, there is documentation of postoperative epidural scarring with persistent right lower extremity radiculopathy, axial low back pain out of proportion to leg pain with interspace collapse and Modic changes, and Grade 1 unstable anterolisthesis and spondylolisthesis. However, despite documentation of a L4-L5 and L5-S1 fusion surgery, there is no documentation that the patient is at a high risk of developing venous thrombosis. In addition, there is no documentation that the use of the Vascutherm unit will not exceed the recommended guideline (up to 7 days, including home use). Therefore, based on guidelines and a review of the evidence, the request for Vascutherm DVT unit is not medically necessary.

