

Case Number:	CM14-0073977		
Date Assigned:	07/16/2014	Date of Injury:	10/24/2000
Decision Date:	09/08/2014	UR Denial Date:	04/24/2014
Priority:	Standard	Application Received:	05/21/2014

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 Anesthesiology, 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 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 50 year old female with a 10/24/00 date of injury. At the time (2/11/14) of request for authorization for Purchase of Biomet Bone Stimulator, Home Health Services two times a week for two weeks (2x2) (wound care and activities of daily living), and Post-operative Aqua Therapy two times a week for six weeks (2x6), there is documentation of subjective (constant severe low back pain radiating to the lower extremities with numbness and weakness) and objective (antalgic gait, tenderness to palpation over the lumbar spine, limited lumbar range of motion, decreased sensation in the right lower extremity, and decreased strength of the right extensor hallucis longus and gastrocnemius) findings, current diagnoses (L4-5 Grade II spondylolisthesis, degenerative disc disease, and stenosis; constant severe low back pain, and lower extremity radiculopathy), and treatment to date (lumbar epidural steroid injections). In addition, there is documentation of a pending lumbar decompression and fusion surgery at L4-5 that has been certified/authorized on 4/24/14. Regarding the Purchase of Biomet Bone Stimulator, there is no documentation that the patient has 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). Regarding Home Health Services two times a week for two weeks (2x2) (wound care and activities of daily living), there is no documentation that the patient requires recommended 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) and that the patient is homebound on a part-time or intermittent basis. Regarding Post-operative Aqua Therapy two times a week for six weeks (2x6), there is no documentation of a condition/diagnosis where reduced weight bearing is

desirable (extreme obesity, need for reduced weight bearing, or recommendation for reduced weight bearing).

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase Of Biomet Bone Stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Bone Growth Stimulators (BGS).

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 L4-5 Grade II spondylolisthesis, degenerative disc disease, and stenosis; constant severe low back pain, and lower extremity radiculopathy. In addition, given documentation of a pending lumbar decompression and fusion surgery at L4-5 that has been certified/authorized, there is documentation that electrical bone growth stimulation will be used as an adjunct to spinal fusion surgery. However, given documentation of a certified/authorized single level fusion, and no documentation of risk factors for failed fusion, there is no documentation that the patient has 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). Therefore, based on guidelines and a review of the evidence, the request for Purchase of Biomet Bone Stimulator is not medically necessary.

Home Health Services 2 X 2 weeks (wound care and ADL): Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the patient requires recommended medical treatment (where homemaker

services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and the patient is homebound on a part-time or intermittent basis, as criteria necessary to support the medical necessity of home health services. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of no more than 35 hours per week. Within the medical information available for review, there is documentation of diagnoses of L4-5 Grade II spondylolisthesis, degenerative disc disease, and stenosis; constant severe low back pain, and lower extremity radiculopathy. In addition, there is documentation of a pending lumbar decompression and fusion surgery that has been certified/authorized. However, despite documentation of a request for home health services for wound care, and given documentation of a request for home health services for activities of daily living, there is no documentation that the patient requires recommended 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). In addition, there is no documentation that the patient is homebound on a part-time or intermittent basis. Furthermore, given documentation of a request for Home Health Services 2 X 2 weeks, there is no (clear) documentation of the proposed number of hours per week. Therefore, based on guidelines and a review of the evidence, the request for Home Health Services 2 X 2 weeks (wound care and activities of daily living) is not medically necessary.

Postop Aqua Therapy 2 X 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine; Aquatic therapy Page(s): 98, 22.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that aquatic therapy is recommended where reduced weight bearing is desirable (such as extreme obesity, need for reduced weight bearing, or recommendation for reduced weight bearing), as criteria necessary to support the medical necessity of aquatic therapy. MTUS Postsurgical Treatment Guidelines identifies up to 34 visits of post-operative physical therapy over 16 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS postsurgical treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of L4-5 Grade II spondylolisthesis, degenerative disc disease, and stenosis; constant severe low back pain, and lower extremity radiculopathy. In addition, there is documentation of a pending lumbar decompression and fusion surgery that has been certified/authorized. However, there is no documentation of a condition/diagnosis where reduced weight bearing is desirable (extreme

obesity, need for reduced weight bearing, or recommendation for reduced weight bearing). Therefore, based on guidelines and a review of the evidence, the request for Post-operative Aqua Therapy 2 X 6 weeks is not medically necessary.