

<b>Case Number:</b>	CM14-0142920		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	01/23/2009
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2014

### 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 Spine Surgeon 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 49-year-old female who reported an injury on 01/23/2009. The mechanism of injury was lifting. Her diagnoses included lumbar herniated nucleus pulposus and L3-4 spondylolisthesis. Her past treatments have included occipital blocks, medial branch blocks, radiofrequency ablation, and lumbar epidural steroid injections. Within the clinical note dated 04/10/2014, it was noted that the injured worker had complaints of moderate to severe tenderness in the low back with moderate decreased range of motion, she stated most of the pain was on the left side. Upon physical exam there were dysesthesias noted over the left buttocks. The injured worker had a positive straight leg raise on the left side and mechanical pain with range of motion. Her medications included Norco, Neurontin, Valium, Depakote, Ambien and Zomig. The treatment plan was not included. The rationale for the requests was not specified. The Request for Authorization forms were signed and dated 07/07/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Orthofix bone growth stimulator:** Overturned

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

**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, Bone growth stimulators

**Decision rationale:** The request for Orthofix bone growth stimulator is medically necessary. The injured worker was authorized for an L3-4 fusion. The Official Disability Guidelines state bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any risk factors for failed fusion, which may include 1 or more previous failed spinal fusions, grade 3 or worse spondylolisthesis, fusion to be performed at more than 1 level, current smoking habit, diabetes, renal disease or alcoholism or significant osteoporosis, which has been demonstrated on radiographs. The documentation submitted for review indicates that the injured worker is a smoker with a 10 cigarette a day habit. Therefore, the request is supported as the injured worker has increased risk for failed fusion. As such, the request for Orthofix bone growth stimulator is medically necessary.

**Vascutherm cold unit:** 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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & leg, Continuous-flow cryotherapy

**Decision rationale:** The request for Vascutherm cold unit is not medically necessary. The injured worker was authorized for an L3-4 fusion. The Official Disability Guidelines state that continuous-flow cryotherapy units may be supported for up to 7 days after surgery. As the injured worker has been authorized for surgery, use for 7 days would be supported. However, the request, as submitted, failed to indicate 7 days use. Therefore, the request for VasCuTherm cold unit is not medically necessary.

**Home health evaluation:** Upheld

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

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

**Decision rationale:** The request for home health evaluation is not medically necessary. The injured worker was authorized for an L3-4 fusion. The California MTUS Guidelines state that home health services are recommended for patients who are homebound on a part time or intermittent basis, generally up to no more than 35 hours per week. The documentation provided for review gives no indication that the injured worker is homebound and the type of medical treatment required was not specified. Therefore, the request for home health evaluation is not medically necessary.

**Aqua therapy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

**Decision rationale:** The request for aqua therapy is not medically necessary. The injured worker was authorized for an L3-4 fusion. The California MTUS Guidelines state aquatic therapy is recommended as an alternative to land-based physical therapy when reduced weight bearing exercise is desired. While the injured worker will require postoperative physical therapy following her surgery, there is a lack documentation of indicating why she would require aquatic therapy as opposed to land based therapy. Additionally, the request as submitted does not include the number of visits being requested. Therefore, the request for aqua therapy is not medically necessary.