

<b>Case Number:</b>	CM14-0188288		
<b>Date Assigned:</b>	11/18/2014	<b>Date of Injury:</b>	07/11/2008
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	10/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 Family 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 44 year old female patient who sustained a work related injury on 7/11/2008. Patient sustained the injury due to cumulative trauma. The current diagnoses include internal disruption at L4-5 and L5-S1. Per the doctor's note dated 10/25/14, physical examination revealed 2+ lumbar paraspinous muscle spasm, tenderness to palpation, flexion 60 degrees: extension 25 degrees: right side bending 25 degrees: left side bending 25 degrees, 2 + reflexes, 5/5 strength, normal sensation and negative straight leg rising (SLR). The current medication lists include Tramadol, Naprosyn and Prilosec. Diagnostic imaging reports were not specified in the records provided. The patient is scheduled for anterior lumbar inter body fusion L4-5 and L5-S1. The patient's surgical history includes hysterectomy. Any operative/ or procedure note was not specified in the records provided. Other therapy done for this injury was not specified in the records provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Rental/purchase bone growth stimulator 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 -Bone Growth Stimulator Unit.

**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 (updated 11/21/14) Bone Growth Stimulators (BGS).

**Decision rationale:** ACOEM/MTUS state guideline does not specifically address this issue. Per the ODG guidelines cited below, use of bone growth stimulators is "Under study. There is conflicting evidence, so case by case recommendations are necessary (some RCTs with efficacy for high risk cases). Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis, instability, a smoker)." In addition per the cited guidelines "Criteria for use for invasive or non-invasive electrical bone growth stimulators: Either invasive or noninvasive methods of electrical bone growth stimulation 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. (Kucharzyk, 1999) (Rogozinski, 1996) (Hodges, 2003)". Any indication listed above that would require a bone growth stimulator is not specified in the records provided. Any evidence of high risk cases (e.g., revision pseudoarthrosis, instability, a smoker) was not specified in the records provided. Any evidence of history of Grade III or worse spondylolisthesis is not specified in the records provided. Any evidence of a current smoking habit is not specified in the records provided. Medical history of Diabetes, Renal disease, Alcoholism or severe osteoporosis is not specified in the records provided. Any operative note was not specified in the records provided. The medical necessity of the request for rental/purchase bone growth stimulator unit is not fully established in this patient. Therefore, the rental/purchase of the bone growth stimulator unit is not medically necessary.

**Tens Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation) Page(s): 114.

**Decision rationale:** According the cited guidelines, electrical stimulation (TENS), is "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)." According the cited guidelines, Criteria for the use of TENS is "-

There is evidence that other appropriate pain modalities have been tried (including medication) and failed.- A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted". Any evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. Patient has received an unspecified number of physical therapy (PT) visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. In addition a treatment plan including the specific short- and long-term goals of treatment with the TENS unit was not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use TENS as an adjunct to a program of evidence-based functional restoration. Any evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse was not specified in the records provided. The medical necessity of the request for the Tens Unit is not fully established for this patient. Therefore, Tens unit is not medically necessary and appropriate.

**DVT (deep vein thrombosis) care personal circulation unit x 30 day rental: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip Chapter Venous Thrombosis.

**Decision rationale:** The exact contents of the DVT Care Personal Circulation unit were not specified in the records provided. Per the cited guidelines, regarding venous thrombosis, "Recommend identifying subjects who are at a high risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy." The rationale for not using anticoagulation therapy for preventing DVT was not specified in the records provided. Whether the pt has been identified as a high risk patient for developing venous thrombosis was not specified in the records provided. There is no high grade scientific evidence to support the routine use of mechanical thrombo-prophylaxis after spinal fusion surgery. A rationale for using the DVT care personal circulation unit was not specified in the records provided. The medical necessity of the request for DVT care personal circulation unit x 30 day rental is not fully established in this patient. Therefore, DVT (deep vein thrombosis) care personal circulation unit x 30 day rental is not medically necessary and appropriate.

**Post OP home health nurse daily dressing change wound care x 14 days: 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); Home Health Services

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 11/21/14) Home Health Services

**Decision rationale:** Per the CA MTUS guidelines cited below, regarding home health services ".....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 request was for post op home health nurse. The patient was certified for fusion surgery for the lumbar spine, however the records do not specify if the surgery has been done or not. Any documented evidence that the patient was totally homebound or bedridden is not specified in the records provided. A medical need for home health service like administration of IV fluids or IV medications was not specified in the records provided. Homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not considered medical treatment. The presence or absence of any family members for administering that kind of supportive care is not specified in the records provided. .The medical necessity of the request for Post OP Home health nurse daily dressing change wound care x14 days is not fully established in this patient. Therefore, the request for home health is not medically necessary and appropriate.