

Case Number:	CM15-0210906		
Date Assigned:	10/29/2015	Date of Injury:	08/07/2011
Decision Date:	12/21/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Minnesota, Florida
 Certification(s)/Specialty: Orthopedic Surgery

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 50 year old female, who sustained an industrial injury on 08-07-2011. The injured worker is currently temporarily totally disabled. Medical records indicated that the injured worker is undergoing treatment for cervical spondylitic myeloradiculopathy at C5-6. Treatment and diagnostics to date has included cervical spine MRI and medications. Recent medications have included Tramadol. Subjective data (06-17-2015 and 08-05-2015), included "severe" neck pain with numbness and tingling down her arm. Objective findings (08-05-2015) included cervical paraspinous muscle spasm with tenderness to palpation and decreased sensation to the C5-6 dermatome on the right. The treating physician noted that "the new MRI shows spinal cord compression with bilateral foraminal narrowing." The request for authorization dated 09-04-2015 requested bone growth stimulator unit, front wheeled walker, and 3 in 1 commode. The Utilization Review with a decision date of 10-07-2015 non-certified the request for associated surgical services-bone growth stimulator for the cervical spine, front wheeled walker for the cervical spine, and 3 in 1 commode for the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Bone Growth Stimulator cervical spine: 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) Treatment for Workers Compensation, Online Edition, 2015, Chapter: Neck & Upper Back (updated 6/25/15): Bone Growth Stimulators (BGS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Neck and upper back, Topic: Bone growth stimulator.

Decision rationale: The injured worker is a 50-year-old female with a date of injury of 8/7/2011. Her diagnosis is C5-6 myeloradiculopathy. The documentation submitted indicates that a request for anterior cervical discectomy and fusion at C5-6 was noncertified. Associated surgical requests have also been noncertified the current request pertains to a bone growth stimulator, front-wheeled walker, and a 3 in one bedside commode. With regard to the request for a bone growth stimulator ODG guidelines are used. The criteria for use of electrical bone growth stimulators are the following: 1. 1 or more previous failed spinal fusions. 2. Grade 3 or worse spondylolisthesis. 3. Fusion to be performed at more than one level. 4. Current smoking habit. 5. Diabetes, renal disease, alcoholism or 6. Significant osteoporosis which has been demonstrated on radiographs. In this case, the above criteria do not apply. A single level fusion is requested and there is no indication of prior failed fusion, grade 3 or worse spondylolisthesis, current smoking habit, diabetes, renal disease, alcoholism or significant osteoporosis. As such, the request for a bone growth stimulator is not supported and the medical necessity of the request has not been established. The request is not medically necessary.

Associated surgical service: Front Wheel Walker Cervical Spine: 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) Treatment for Workers Compensation, Online Edition, 2015, Chapter: Knee & Leg walking aids (canes, crutches, braces, orthoses & walkers) (updated 07/10/15).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Knee, Topic: DME Walking aids.

Decision rationale: With regard to the request for a front-wheeled walker, the guidelines support walking aids. The documentation indicates the presence of myelopathy and as such a postoperative walking aid is supported. However, the available documentation does not indicate certification of the surgical procedure. As such, the request for a front-wheeled walker to be used after surgery is not supported and the medical necessity of the request has not been established. The request is not medically necessary.

Associated surgical service: 3 in 1 commode cervical spine: 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) Treatment

for Workers Compensation, Online Edition, 2015, Chapter: Neck & Upper Back (updated 6/25/15).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Knee, Topic: Durable Medical Equipment.

Decision rationale: With regard to a 3 in one bedside commode, the documentation does not indicate that the injured worker is bed or room confined or will be after surgery. ODG guidelines indicate that certain durable medical equipment toilet items such as commodes are medically necessary if the patient is bed or room confined. Furthermore, the documentation does not indicate that surgery has been certified. As such, the request for a bedside commode is not supported and the medical necessity of the request has not been substantiated. The request is not medically necessary.