

Case Number:	CM15-0094494		
Date Assigned:	05/22/2015	Date of Injury:	01/10/2015
Decision Date:	06/25/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/15/2015

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: Illinois, California, Texas
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 28-year-old male who sustained an industrial injury on 1/10/15. Injury occurred when he was pulling a large diameter fire hose in between his legs and overextended with his right hand to pull and experienced an onset of low back pain and locking up. Past medical history was reported as unremarkable. He was a non-smoker. Conservative treatment included physical therapy, activity modification, and medications. The 2/12/15 lumbar spine x-rays revealed partial spina bifida with a very thin L5 lamina and an absent S1 lamina. There was slight retrolisthesis of L4 on L5 and spondylolisthesis of L5 on S1. There was an unusual variant with a significant deformity through the pars that could be classified as a congenital spondylolisthesis in correlation to his spina bifida. The 3/2/15 lumbar spine MRI impression documented spondylolysis at L5 with 2 mm of spondylolisthesis of L5 on S1. Findings were suggestive of chronic pars defect. There was a 3 mm central disc protrusion at L4/5 that indented the thecal sac without compressing the associated nerve roots. There was 2 mm retrolisthesis of L4 on L5/S1. The 4/29/15 treating physician report cited increased low back pain that was very debilitating. Lumbar spine exam documented midline L5/S1 tenderness, painful and restricted lumbar range of motion, normal lower extremity motor strength and sensation, and diminished left ankle reflex. The treatment plan recommended anterior lumbar interbody fusion at L5/S1 with instrumentation and allograft. Requests for associated surgical services/equipment were submitted. The 5/12/15 utilization review certified the requests for anterior lumbar interbody fusion L5/S1 with instrumentation and allograft, home therapy 3x2, post-operative physical therapy 2x5, pre-operative labs and EKG, chest x-ray, lumbosacral orthosis brace, pre-operative clearance, assistant surgeon and inpatient stay for 2-3 days. The request for a bone growth stimulator was non-certified as only a one-level fusion was to be

performed. The request for 2- week rental of a motor cold therapy unit was non-certified as there was no evidence that a mechanical cold therapy unit would provide additional benefit over conventional ice packs. The request for a home nurse for daily dressing changes for 2 weeks was non-certified as there was no clear rationale to support the need for daily dressing changes for a one level fusion or why the injured worker would not be able to change the anterior dressing independently.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bone Growth Stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Criteria for use for invasive electrical bone growth stimulators.

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 & Thoracic Bone growth stimulators (BGS).

Decision rationale: The California MTUS guidelines are silent regarding bone growth stimulators. The Official Disability Guidelines indicate that bone growth stimulators are under study and may be considered medically necessary as an adjunct to lumbar 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; (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. Guideline criteria have not been met. This injured worker is a candidate for anterior lumbar interbody fusion at L5/S1 with instrumentation and allograft. There is no evidence that he has any significant risk factors for delayed fracture healing or non-union to support the medical necessity of a bone growth stimulator at this time. Therefore, this request is not medically necessary.

Motorized Cold Therapy X 2 Week Rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Cold/Heat packs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

Decision rationale: The California MTUS are silent regarding hot/cold therapy devices, but recommend at home applications of hot or cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no

compelling reason submitted to support the medical necessity of a hot/cold therapy unit in the absence of guideline support or over standard cold packs. Therefore, this request is not medically necessary.

Home Nurse Dressing Change - Daily for 2 Weeks: Upheld

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

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

Decision rationale: The California MTUS recommends home health services only for otherwise recommended treatment for patients who are homebound, on a part time or intermittent basis. There is no rationale provided in the submitted records to support the medical necessity of this request. The injured worker is undergoing anterior lumbar interbody fusion. There is no detailed reason presented as to why he would not be able to change the dressing independently. Therefore, this request is not medically necessary.