
Notice of Independent Medical Review Determination

Dated: 11/21/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/15/2013
Date of Injury:	3/1/2010
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004224

- 1) MAXIMUS Federal Services, Inc. has determined the request for **transportation (round trips) Qty. 4 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **front wheeled walker is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **commode 3 in 1 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **in-home nurse four hours a day for two weeks Qty. 56 is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for an **external bone growth stimulator is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **in home caregiver times two weeks Qty. 50 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **transportation (round trips) is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **front wheeled walker is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **commode 3 in 1 is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **in-home nurse four hours a day for two weeks Qty. 56 is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **external bone growth stimulator is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **in home caregiver times two weeks Qty. 50 is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

This claimant is a 50-year-old male with multiple complaints of pain. Mechanism of injury was pulling a large piece of metal. The claimant was seen and reported pain to his cervical spine, lumbosacral spine, and left knee. MRI of the lumbar demonstrated a grade I spondylolisthesis of L5 on S1. There was an 8 mm posterior upward protrusion as well. An L5-S1 posterior lumbar decompression and fusion was certified. On 07/22/2013, this claimant was seen and noted the patient was worse in his lumbar spine. Straight leg raise was reported at 75 degrees and he had 4/5 weakness. The patient is diagnosed with spondylolisthesis L5-S1 status post lumbar fusion. Treatment plan includes transportation; front wheeled walker; commode 3 in 1; in home nurse four hours a day for two weeks; bone growth stimulator; in home care provider times two weeks per hour for a quantity of fifty.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for transportation (round trips) Qty. 4:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence-based guidelines for its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on The Official Disability Guidelines (ODG) Knee Chapter, which is not a part of the MTUS.

Rationale for the Decision:

This request is for transportation round trip. California MTUS/ACOEM and Official Disability Guidelines Low Back Chapter does not specifically address this issue. Official Disability Guidelines, Knee Chapter indicates that transportation to and from appointments is recommended as medically necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. After a review of the records submitted, on 07/02/2013 an orthopedic spine supplement report was submitted by [REDACTED], MD and this failed to disclose any significant progressive neurological deficits that would keep this employee from providing transportation on their own. The records provided for this review fail to document a medical necessity for transportation. They do not note that this employee acknowledges any medications at this time that are causing significant adverse effects that would cause an inability to drive. The records do not indicate that there are significant motor deficits, reflex deficits, sensory deficits, or significant functional deficits that would preclude driving. The records do not indicate that there are other significant factors not specifically described that would preclude the employee from driving. **The request for transportation (round trips) Qty. 4 is not medically necessary and appropriate.**

2) Regarding the request for a front wheeled walker:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, Contents, Treatment Guidelines, 18th Edition [2013 web] Knee Section-Walking Aids, which is not a part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Official Disability Guidelines (ODG) KNEE CHAPTER, Durable Medical Equipment, which is not a part of the MTUS.

Rationale for the Decision:

CA MTUS/ACOEM and Official Disability Guidelines, Low Back Chapter does not address this issue. Official Disability Guidelines, Knee Chapter, in discussing durable medical equipment, indicate that durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. A review of the records provided for this review failed to indicate medical necessity for a front wheeled walker. The records do not indicate significant mobility issues that would preclude this employee from walking normally. Although the surgical intervention itself has been certified, there is lack of documentation of a physical therapy evaluation demonstrating post-op necessity for this device. Records do not indicate that post-op immobility is a significant factor although the records do not indicate the employee has undergone the surgical intervention at this time. Medically necessary has not been met by the records provided. **The request for a front wheeled walker is not medically necessary and appropriate.**

3) Regarding the request for commode 3 in 1:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG) Knee Chapter, Durable Medical Equipmentm which is not a part of the MTUS.

Rationale for the Decision:

California MTUS, ACOEM, and ODG Low Back Chapter are silent on the subject of commodes. However, Official Disability Guidelines, Knee Chapter indicates that durable medical equipment can be recommended only if there is a medical

need and if the device or system meets Medicare's definition of durable medical equipment. ODG, Knee Chapter goes on to state, "Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used for convenience in the home. Certain DME toilet items (commodes, bedpans, etc.) are medically necessary if the patient is bed or room confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infections, or conditions that result in physical limitations." The records submitted for review do not describe this employee having any significant physical limitations at this time. The most recent clinical note failed to describe the pain scale and failed to describe the employee's pain scale objectively in a VAS, and failed to describe significant functional deficits that would preclude the employee from going to the toilet on their own. While the records do report pain, as previously described, the employee has 4/5 strength in the gastroc soleus complex and EHL, this would not preclude walking to the bathroom. Records do not indicate that the employee is home bound or bed bound at this time. Therefore, this request is not considered medically necessary per the guidelines. **The request for a Commode 3 in 1 is not medically necessary and appropriate.**

4) Regarding the request for an in-home nurse four hours a day for two weeks Qty. 56:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, Contents, Treatment Guidelines, 18th Edition [2012 web] Spine Section-Home Health Services, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Home Health Services, pg 51, which is a part of the MTUS.

Rationale for the Decision:

CA MTUS Chronic Pain Guidelines indicate that home health services are recommended only for otherwise recommended medical treatment for patients who are home bound, on a part time or "intermittent" basis, generally up to no more than 35 hours per week. The records provided for this review indicate that the requested surgical procedure, an L5-S1 decompression/fusion has been certified. However, the records do not indicate if a post-op nursing evaluation was performed to indicate medical necessity for this request. The records do not indicate if the employee would be home bound post-surgery, either on a part time or intermittent basis and the records do not indicate exactly what type of services would be provided. The records do not indicate any adverse events or indicate special needs that would require nursing for 4 hours a day for 2 weeks. **The request for an in-home nurse four hours a day for two weeks Qty. 56 is not medically necessary and appropriate.**

5) Regarding the request for external bone growth stimulator:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, Contents, Treatment Guidelines, 18th Edition [2013 web] Low Back Section-Bone Growth Stimulators, which is not a part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on ODG Low Back Chapter, Bone growth stimulators, which is not a part of the MTUS.

Rationale for the Decision:

The CA MTUS/ACOEM guidelines are silent on this issue as is MTUS Chronic Pain Guidelines. The Official Disability Guidelines, Back Chapter, states that bone growth stimulators are, "Under study." Official Disability Guidelines, Low Back Chapter, indicates further, "There is conflicting evidence, so case by case recommendations are necessary." Official Disability Guidelines, Back Chapter, goes on to further state that certain criteria should be met if a bone growth stimulator was to be considered reasonable on a case by case basis, and this would indicate that there should be documentation of 1 or more previous failed spinal fusions, grade III or worse spondylolisthesis, fusion to be performed at more than 1 level, current smoking habit, diabetes, renal disease, alcoholism, or significant osteoporosis which has been demonstrated on radiographs. The records provided for review do indicate that a lumbar fusion from L5-S1 with decompression has been recommended and certified. This would be a 1 level fusion. Records do not indicate the employee has previously had spinal fusion performed and do not demonstrate a grade III or worse spondylolisthesis. The most recent clinical notes do not indicate a current smoking habit. The most recent clinical notes do not demonstrate that there are significant risk factors such as diabetes. In a Secondary Treating Physician's Followup Orthopedic Evaluation Report dated 03/06/2013, it is noted in when discussing the endocrine system, the employee, "Denies thyroid, parathyroid, or reproductive hormone problems." Records do not demonstrate objective evidence that this employee has significant osteoporosis. As such, a rationale for proceeding with a bone growth stimulator has not been demonstrated by the records. **The request for an external bone growth stimulator is not medically necessary and appropriate.**

6) Regarding the request for an in home caregiver times two weeks Qty. 50:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, Contents, Treatment Guidelines, 18th Edition [2012 web] Spine Section-Home Health Services which is not a part of the MTUS.

The Expert reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines-Home Health Care, pg 51, which is a part of the MTUS.

Rationale for the Decision:

CA MTUS Chronic Pain Guidelines indicate that home health services are, "Recommended only for otherwise recommended medical treatment for patients who are home bound, on a part time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include home maker 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 records provided for review do indicate that a surgical intervention in the form of an L5-S1 decompression and fusion has now been certified. However, the records do not indicate that this employee is currently home bound either on a part time or intermittent basis. The records do not indicate that there is a need for homemaker services like shopping, cleaning, or laundry, or personal care like bathing, dressing, or using the bathroom. The most recent clinical notes fail to indicate that there are significant functional deficits. Records do not indicate that the employee would have a need for home health Services regarding medical treatment and do not indicate that there would be a need for home care services in general. **The request for an in home caregiver times two weeks Qty. 50 is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.