

Case Number:	CM14-0006758		
Date Assigned:	02/07/2014	Date of Injury:	06/17/2010
Decision Date:	06/23/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	01/17/2014

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 Surgery and is licensed to practice in New York. 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 patient has back pain radiating to the left leg. The physical examination shows neurologic findings in the right L5-S1 and there is pain with straight leg raising. There is also weakness in left L5 and S1 motor testing. X-rays in December 2013 shows L5-S1 narrowing with 5 mm of flexion-extension motion at this segment. The patient has had prior medications physical therapy injections and chiropractic treatment. Surgery for the L4-5 and L5-S1 segments has been requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

BONE GROWTH STIMULATOR (UNSPECIFIED TYPE OR DURATION): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 117-121.

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
Chapter, Bone Growth Stimulator Section.

Decision rationale: The medical records do not indicate that this patient has any define risk factors for nonunion of spinal surgery. In addition to reinforce spinal fusion levels are not been conducted. Diffusion is limited L4-5 and L5-S1. Guidelines for the use of bone growth

stimulator at the spinal surgery are not met. Again the medical records do not document patient has any significant risk factors for nonunion.

MUSCLE STIMULATOR (UNSPECIFIED DURATION): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 117-121

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Muscle Stimulation Section, pages 117-121..

Decision rationale: The California Guidelines do not support the muscle stimulation after lumbar spinal surgery. There is no literature support the use of this device and no evidence that this delay supports good results were improved outcomes after spinal surgery. Muscle stimulation unit is not medically necessary in this case.

HOT/COLD THERAPY UNIT RENTAL OR PURCHASE: 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 Chronic Pain Medical Treatment Guidelines, pages 117-121.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The use of a hot and cold therapy unit has not been shown to improve outcomes of the lumbar spinal fusion surgery. The guidelines do not support the use of hot cold therapy after lumbar spine surgery. Guidelines for the hot cold therapy are not met with respect to this patient's lumbar fusion.