

Case Number:	CM14-0106128		
Date Assigned:	07/30/2014	Date of Injury:	05/20/2008
Decision Date:	08/29/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	07/08/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 52-year-old male who reported an injury on 05/20/2008 due to repetitive use of a jackhammer while performing his regular work duties. Diagnoses for the injured worker were cervical stenosis, (s/p cervical fusion), lumbar spinal stenosis, L4-5 herniated nucleus pulposus, and bilateral shoulder impingement syndrome. Past treatments for the injured worker have been medications and physical therapy and cortisone injections. MRI of lumbar spine on 06/06/2014 revealed severe canal stenosis at L4-5. The retrolisthesis at L4-5 was completely reduced. There was moderate to severe canal stenosis at L3-4 as well. MRI of thoracic spine dated 06/06/2014 revealed multilevel thoracic spondylosis at T5-6, T6-7, T7-8, T8-9, T9-10, and T10-11 with disc extrusion at C7-8, there was preservation of cerebral spinal fluid around the cord. The injured worker's past surgeries included a C5-6, C6-7 discectomy with fusion and instrumentation, left shoulder arthroscopy with subacromial decompression distal clavicle excision and labral debridement, left shoulder rotator cuff tendinitis and labral tearing. The injured worker had a physical examination on 06/06/2014 with complaints of low back pain that radiated into both legs. Examination revealed 5/5 strength in bilateral upper extremities, tenderness to palpation of the lower lumbosacral region. Straight leg raise was positive for low back pain and bilateral leg pain. Asymmetric reflexes with hyperreflexia bilateral lower extremity. Medications for the injured worker were glipizide, metformin, gemfibrozil, Prilosec, lisinopril and Norco. Treatment plan for the injured worker was for anterior-posterior surgery at L4-5, anterior interbody fusion at L4-5 to reduce retrolisthesis, and distract the space at L4-5 using bone graft and Infuse as well as instrumentation at L4-5 and posteriorly place pedicle screws at L4-5. The rationale and Request for Authorization were not submitted for review.

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 (ODG), Treatment section for the low back under the heading of Bone Growth Stimulation.

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 Pain, Bone Growth Stimulators.

Decision rationale: The injured worker is a 52-year-old male who reported an injury on 05/20/2008 due to repetitive use of a jackhammer while performing his regular work duties. Diagnoses for the injured worker were cervical stenosis, (s/p cervical fusion), lumbar spinal stenosis, L4-5 herniated nucleus pulposus, and bilateral shoulder impingement syndrome. Past treatments for the injured worker have been medications and physical therapy and cortisone injections. MRI of lumbar spine on 06/06/2014 revealed severe canal stenosis at L4-5. The retrolisthesis at L4-5 was completely reduced. There was moderate to severe canal stenosis at L3-4 as well. MRI of thoracic spine dated 06/06/2014 revealed multilevel thoracic spondylosis at T5-6, T6-7, T7-8, T8-9, T9-10, and T10-11 with disc extrusion at C7-8, there was preservation of cerebral spinal fluid around the cord. The injured worker's past surgeries included a C5-6, C6-7 discectomy with fusion and instrumentation, left shoulder arthroscopy with subacromial decompression distal clavicle excision and labral debridement, left shoulder rotator cuff tendinitis and labral tearing. The injured worker had a physical examination on 06/06/2014 with complaints of low back pain that radiated into both legs. Examination revealed 5/5 strength in bilateral upper extremities, tenderness to palpation of the lower lumbosacral region. Straight leg raise was positive for low back pain and bilateral leg pain. Asymmetric reflexes with hyperreflexia bilateral lower extremity. Medications for the injured worker were glipizide, metformin, gemfibrozil, Prilosec, lisinopril and Norco. Treatment plan for the injured worker was for anterior-posterior surgery at L4-5, anterior interbody fusion at L4-5 to reduce retrolisthesis, and distract the space at L4-5 using bone graft and Infuse as well as instrumentation at L4-5 and posteriorly place pedicle screws at L4-5. The rationale and Request for Authorization were not submitted for review.