

Case Number:	CM14-0053306		
Date Assigned:	07/07/2014	Date of Injury:	06/19/2010
Decision Date:	08/06/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	04/21/2014

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 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 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 05/19/2010. The mechanism of injury was not stated. Current diagnoses include degenerative disc disease in the lumbar spine and facet arthropathy at L3-4, L4-5 and L5-S1. The injured worker was evaluated on 02/26/2014 with complaints of moderately severe lumbar spine pain. Physical examination on that date revealed tenderness to palpation over the facet joints at L4-5 bilaterally, moderate paraspinal muscle guarding and tenderness, limited range of motion, sciatic notch tenderness, hypoesthesia of the dorsum of the right foot, weakness in the right lower extremity, 2+ deep tendon reflexes at the bilateral knees, 1+ deep tendon reflexes at the bilateral ankle and positive sciatic stretch testing on the right. X-rays obtained in the office on that date indicated a loss of disc space height at L3-4, L4-5 and L5-S1 with anterior osteophytes and retrolisthesis of L3-4. Flexion and extension x-rays of the lumbar spine, obtained in the office on that date, indicated negative instability. Treatment recommendations at that time included authorization for a decompression laminectomy and discectomy with L4-5 posterolateral fusion.

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 (Acute and Chronic) Procedure Summary - Bone Growth Stimulator under study.

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.

Decision rationale: The Official Disability Guidelines state that either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with risk factors for failed spinal fusion, including 1 or more previous failed spinal fusions, grade III or worse spondylolisthesis, fusion to be performed at more than 1 level, a current smoking habit, diabetes, renal disease, alcoholism or significant osteoporosis. As per the documentation submitted for this review, the injured worker is pending authorization for a discectomy, laminectomy and fusion at L4-5. The injured worker does not meet any of the above-mentioned criteria as outlined by the Official Disability Guidelines. Therefore, the current request cannot be determined as medically appropriate. There was also no indication that this injured worker's surgical procedure has been authorized. As such, the request is non-certified.

Cold Therapy Unit: 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 (Acute and Chronic) - Procedure Summary - Cold/Heat Packs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Continuous- Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines do not recommend continuous flow cryotherapy for the spine. As per the documentation submitted for this review, the injured worker is pending authorization for a lumbar laminectomy, discectomy and fusion. There is no mention of a contraindication to at-home local applications of cold packs as opposed to a motorized unit. Based on the clinical information received and the above-mentioned guidelines, the request is non-certified.