

Case Number:	CM14-0073695		
Date Assigned:	07/16/2014	Date of Injury:	10/24/2012
Decision Date:	08/29/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	05/21/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 62-year-old male who reported an injury on 10/24/2012. The injured worker sustained a work related injury due to continuous trauma in his regular work duties which entailed loading and unloading drums containing oil, dirt, and debris. He injured his back, thoracic spine, and bilateral shoulders. Treatment history included epidural steroid injections, x-rays, CT scan, MRI, and medications. Evaluation dated 04/26/2014, documented the injured severe back pain and radiating right leg pain. The physical examination revealed there was 2+ lumbar paraspinous muscle spasm. There was tenderness to palpation of these muscles. The range of motion of the lumbosacral spine was flexion 60 degrees, and extension and right/left side bending was 25 degrees. Deep tendon reflexes right/left for the knee and ankle were 2+. The injured worker had decreased sensation at L5-S1 dermatome on the right. The straight leg raising was positive on the right at 60 degrees. Diagnoses included grade 1 spondylolisthesis at L5-S1 with bilateral pars fracture and right leg radiculopathy, herniated nucleus pulposus L5-S1, and bone-on-bone disc space collapse at L5-S1. In the documentation, the provider noted the patient history and subjective complaints correlated with physical findings and diagnostic studies. The injured worker has reached his maximum medical benefit from conservative and nonoperative at the present time and he is a surgical candidate. It appears the injured worker's surgery has been authorized. The provider was going to schedule the injured worker for an anterior posterior fusion. On the same day the provider will do the anterior approach first to reconstitute the disc height and stabilize the spine with interbody cage and second staged procedure would be done same day during the posterior lumbar laminectomy at L5 and partial S1 to decompress the cauda equina nerve roots and stabilize posteriorly with pedicle screws L5-S1. The request for authorization or rationale were not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of Bone Growth Stimulator unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Problems Bone Growth Stimulator.

Decision rationale: According to the Official Disability Guidelines (ODG) state that bone growth stimulator is under study. There is conflicting evidence, so case by case recommendations are necessary (some RCTs with efficacy for high risk cases). Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis, instability, and smoker). There is no consistent medical evidence to support or refute use of these devices for improving patient outcomes; there may be a beneficial effect on fusion rates in patients at high risk, but this has not been convincingly demonstrated. The criteria for use for invasive or non-invasive electrical bone growth stimulator; may be considered medically necessary as an adjunct to spinal fusion surgery patients with any of the following risk factors for failed fusion; one or more previous failed spinal fusions; grade III or worse spondylolisthesis; fusion to be performed at more than on level; Current smoking habit; Diabetes, Renal disease, Alcoholism; or significant osteoporosis which has been demonstrated on radiographs. The documents submitted for review failed to indicate if the injured worker had any of the above criteria to warrant a purchase for a bone stimulator. In addition the surgery has been authorized but a date was not submitted for review. In addition the request submitted for review failed to indicate where the bone stimulator is required for the injured worker. Given the above the request do not support the guidelines to warrant a purchase of a bone growth stimulator unit.

30 days rental of Transcutaneous Electrical Nerve Stimulation Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 114-116.

Decision rationale: The Chronic Pain Medical Treatment Guidelines do not recommend a TENS unit as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration and other ongoing pain treatment including medication usage. It also states that the TENS unit is recommended for neuropathic pain including diabetic neuropathy and post-herpetic neuralgia. The guidelines recommends as a treatment option for acute post-

operative pain in the first thirty days post-surgery. The documents submitted indicated the injured worker was authorized for surgery, however the date was not submitted. The provider failed to indicate long- term functional restoration goals for the injured worker. In addition the request for failed to indicate location where the TENS unit will be applied on the injured worker. Given the above, the request for 30 days rental of transcutaneous electrical nerve stimulation (TENS) unit is not medically necessary and appropriate.