

Case Number:	CM14-0207294		
Date Assigned:	12/19/2014	Date of Injury:	09/22/2003
Decision Date:	02/25/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/10/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 47-year-old male who reported an injury on an unspecified date due to an unspecified mechanism of injury. On 11/17/2014, he presented for a followup medical evaluation. He reported low back pain with associated leg pain. It was stated that he had diagnoses of low back pain and disorder of the trunk. He also stated that the pain radiated through his right buttock into the right leg with associated numbness and tingling in the right thigh to the right knee. A physical examination of the lumbar spine showed tenderness to palpation about the paralumbar musculature with related spastic activity over the facets. He also exhibited asymmetric deep tendon reflexes with depressed reflexes in the left. Documentation regarding the injured worker's medication, past treatments, surgical history, and diagnostic studies, was not provided. The treatment plan was for a cold therapy unit and bone growth stimulator. The Request for Authorization form was signed on 11/21/2014. The rationale for the request was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 (ODG), Treatment Index, 12th edition, (web), Low Back, 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) Knee and Leg, Continuous Flow Cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy for following surgery for up to 7 days but not for nonsurgical treatment. According to the documentation provided, the RFA shows that a request was made for an L5-S1 decompression and fusion with instrumentation. While cold therapy units are normally recommended for postoperative use for up to 7 days, the request failed to mention the duration of the cold therapy unit that was being requested. In addition, it was not stated if it was being requested for a rental or purchase. In the absence of this information, the request would not be supported by the evidence based guidelines. As such, the request is not medically necessary.

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 Index, 12th edition, (web), Low Back, Bone growth stimulators (BGS)

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, Bone Growth Stimulators.

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 any of the following risk factors for failed fusion: (1) 1 or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than 1 level; (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor); (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. The Request for Authorization shows that the injured worker was requesting an L5-S1 decompression and fusion with instrumentation. However, there is no documentation showing that the injured worker meets the above cited criteria listed within the guidelines to support the requested bone growth stimulator. In the absence of this information, the request would not be supported by the evidence based guidelines. As such, the request is not medically necessary.