

<b>Case Number:</b>	CM15-0143172		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	03/01/2012
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	07/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2015

### 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: California, Indiana, New York  
 Certification(s)/Specialty: Internal Medicine

### 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 49 year old male, who sustained an industrial injury on 03-01-2012. On provider visit dated 05-11-2015 the injured worker has reported severe back pain that radiates mainly into the left leg and left testicle associated with weakness and numbness sensation, and atrophy of the left leg. The injured worker was noted to develop numbness sensation in the legs after standing for over 10 minute. On examination strength were 4 out of 5 of the left dorsiflexors, plantar flexors and hamstring muscles. There was noted sensory loss to light touch, pinprick and two-point discrimination in the dorsal and plantar aspect of the left foot. Left ankle jerk was reduced on deep tendon reflexes. Gait was noted as slow with a left leg limp. The injured worker was noted that he was unable to stand on his left leg due to severe muscle spasm on the lumbosacral musculature area. Positive Tinel's sign was noted in the distribution of the left peroneal nerve just below the head of the fibula. Range of motion increase back pain that radiated mainly into the left leg. The diagnoses have included lumbar radiculopathy. Treatment to date has included laboratory studies, medication, physical therapy and surgical intervention. The injured worker was noted to have undergone MRI's, Electromyogram and nerve conduction studies, and CT of the lumbar spine. The provider requested bone growth stimulator - purchase and lumbar wrap.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **Bone Growth Stimulator - purchase: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Bone Growth Stimulators.

**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 section, Bone growth stimulator.

**Decision rationale:** Pursuant to the Official Disability Guidelines, bone growth stimulator-purchase is not medically necessary. Bone growth stimulators (BGS) are under study. There is conflicting evidence, so case-by-case recommendations are necessary. Some limited evidence exists for improving diffusion rate of spinal fusion surgery in high-risk cases (e.g. revision pseudo-arthritis, instability, smoker). There is no consistent medical evidence to support or refute the use of these devices for improving patient outcomes. Criteria for use of invasive or noninvasive electrical bone growth stimulators may be considered medically necessary as an adjunct to spinal fusion surgery, for patients with any of the following risk factors for failed fusion: one of our previous failed spinal fusions: grade 3 or worse spondylolisthesis; fusion to be performed at more than one level; current smoking habit; diabetes, renal disease, alcoholism; or significant osteoporosis demonstrated on radiographs. In this case, the injured worker's working diagnoses are lumbar radiculopathy secondary partial collapse disk space at L5 - S1 posterior osteophytes and severe left foraminal stenosis causing compression of exiting L5 left nerve root; and compression left peroneal nerve secondary limping. The date of injury is March 1, 2012. The request for authorization is dated July 7, 2015. The most recent progress note was dated June 6, 2015. The treating provider was seen and examined by the treating neurosurgeon. The treating provider received authorization for an interbody fusion with instrumentation at L5 - S1. Bone growth stimulators (BGS) are under study. Bone growth stimulators are indicated for patients with a current smoking habit, previous failed spinal fusion or fusion to be performed at more than one level, and patients with past medical history of diabetes, renal disease or alcoholism. There is no clinical indication or rationale in the progress note documentation for a bone growth stimulator. There are no other clinical findings documented in the medical record as an indication for a bone growth stimulator. Consequently, absent clinical documentation with a clinical indication and rationale and documentation to support the use of a bone growth stimulator, bone growth stimulator-purchase is not medically necessary.

### **Lumbar Wrap: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Cold/Heat Packs.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Cold/heat packs.

**Decision rationale:** Pursuant to the ACOEM and the Official Disability Guidelines, lumbar wrap is not medically necessary. Cold/heat packs are recommended as an option for acute pain. At home local applications of cold packs in the first few days of acute complaint; thereafter, application of heat packs or cold pack. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. Evidence for application of cold treatment to low back pain is more limited than the therapy. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal activities. In this case, the injured worker's working diagnoses are lumbar radiculopathy secondary partial collapse disk space at L5-S1 posterior osteophytes and severe left foraminal stenosis causing compression of exiting L5 left nerve root; and compression left peroneal nerve secondary limping. The date of injury is March 1, 2012. The request for authorization is dated July 7, 2015. The most recent progress note was dated June 6, 2015. The treating provider was seen and examined by the treating neurosurgeon. The treating provider received authorization for an interbody fusion with instrumentation at L5 - S1. There was no clinical indication or rationale documented in the progress note for a lumbar wrap. At home, local applications of heat and cold therapy are recommended over commercially available products. Consequently, absent clinical documentation with the clinical indication and rationale for a lumbar wrap and absent guideline recommendations, lumbar wrap is not medically necessary.