

Case Number:	CM15-0162295		
Date Assigned:	08/28/2015	Date of Injury:	05/21/2010
Decision Date:	09/30/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	08/18/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 56 year old male who sustained an industrial injury on 5-21-10. He had complaints of neck, upper back, lower back and neck pain with difficulty breathing. Treatments include: medication, physical therapy, aquatic therapy. Progress report dated 7-1-15 reports continued complaints of neck pain that radiates intermittently into both arms, the right greater than the left. The lower back pain is constant with radiation into the legs rated 7 out of 10. He has complaints of bilateral leg weakness and the cervical and lumbar spine have limited range of motion due to pain, the right side greater than the left. Diagnoses include: intervertebral cervical disc degenerative osteoarthritis myelopathy, thoracic sprain and strain, and displacement lumbar disc without myelopathy. Plan of care includes: orthopedic spine 2nd opinion scheduled on 7-6-15 who recommended surgery. Work status: return to modified duty on 7-1-15 no lifting greater than 10 pounds, no repetitive bending, alternate sit and stand as needed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Muscle Stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Electrotherapy, pages 114-118.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of stim Unit include trial in conjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, there is no documentation on what electrical muscle stimulation unit is to be purchased, nor is there any documented short-term or long-term goals of treatment with the unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the stimulator unit purchase. There is no evidence for trial of muscle stimulator unit. Regarding use for post-operative pain with transcutaneous electrical nerve stimulation, it is recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery and appears to be most effective for mild to moderate thoracotomy pain with lesser effect, or not at all for other orthopedic surgical procedures. Rental is also preferred over purchase during this 30-day trial period. Submitted reports have not met guidelines criteria or indication for medical necessity. The Muscle Stimulator is not medically necessary and appropriate.

Bone Growth Stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Bone-growth stimulators (BGS), page 572.

Decision rationale: Guidelines note 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) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one 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. Submitted reports have not demonstrated clinical findings to meet the criteria for the bone growth stimulator. The Bone Growth Stimulator is not medically necessary and appropriate.