

<b>Case Number:</b>	CM15-0232650		
<b>Date Assigned:</b>	12/08/2015	<b>Date of Injury:</b>	04/21/2008
<b>Decision Date:</b>	01/29/2016	<b>UR Denial Date:</b>	11/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/27/2015

### 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: Minnesota, Florida  
 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 67 year old female who sustained an industrial injury on 04-21-2008. According to a progress report dated 07-21-2014, the injured worker had constant low back pain with radiation to the bilateral lower extremities down to the left hip and thigh and calf with associated burning sensation to the right thigh. She also reported numbness and tingling sensation in to the bilateral lower extremities, left worse than right, with associated spasms. She reported burning pain in the right thigh. Her low back felt worse since her last visit. She was participating in a home exercise program. She attended cardiac rehabilitation two to three times a week. Current medications included Oxycodone, Norco, Ibuprofen and Restoril. The injured worker was found to have critical stenosis at L3-4. She was offered surgical decompression and fusion and was approved. During the preoperative clearance, she had been found to have chest discomfort, shortness of breath, chest pain and left arm pain. She was evaluated by a cardiologist and found to have an occlusion. She underwent triple bypass surgery on 01-18-2014. Diagnoses included transition syndrome with resultant instability at L3-L4 and solid fusion at L4-L5, lumbar spine 8 mm spondylolisthesis with instability, status post solid transforaminal lumbar interbody fusion at L4-L5 level and status post open heart surgery on 04-18-2014. The treatment plan included request for re-instatement of previously approved surgery. According to the most recent exam performed on 12-15-2014, the injured worker reported constant mid back pain, constant low back pain radiating to the lower extremities with numbness and tingling and constant right wrist and right hand pain with numbness and tingling. Physical therapy was still pending. The treatment plan included medications, home exercise program and replacement

walker. On 11-02-2015, Utilization Review non-certified the request for associated surgical service: bone growth stimulator 6-9 months lumbar spine per 09-14-2015 order. The request for anterior posterior fusion, decompression with discectomy and possible instrumentation with application of intervertebral biomechanical device, anterior instrumentation, allograft, laminectomy, spinal lamina removal, vertebral corpectomy, and vertebral body removal, L3-4, pre-op clearance, post-op physical therapy, Norco and associated surgical services were authorized.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Associated surgical service: Bone growth stimulator 6-9 months, lumbar spine:** 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), Low Back (updated 09/22/2015), Online version.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Low back. Topic: Bone growth stimulators.

**Decision rationale:** With regard to the request for a bone growth stimulator, ODG guidelines indicate the following criteria: 1. 1 or more previous failed spinal fusions. 2. Grade 3 or worse spondylolisthesis. 3. Fusion to be performed at more than one level. 4. Current smoking habit. 5. Diabetes, renal disease, alcoholism or 6. Significant osteoporosis which has been demonstrated on radiographs. In this case, the documentation provided does not indicate any of the above risk factors. The previous fusion was at L4-5 and is reported to be solid. The medical records submitted do not document grade III Spondylolisthesis. The fusion is to be performed at 1 level. Current smoking habit has not been documented. There is no history of diabetes, renal disease, alcoholism or significant osteoporosis documented. As such, the request for a bone growth stimulator is not supported by evidence-based guidelines and the medical necessity of the request has not been substantiated.