

<b>Case Number:</b>	CM14-0149667		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	12/05/2011
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2014

### 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 Illinois. 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 54 year old male who reported an injury on 12/05/2011. The mechanism of injury was not stated. The diagnoses for this injured worker are herniated nuclear pulposus L4-5 and L5-S1 with left lower extremity radiculopathy. The past medical treatments for this injured worker were epidural steroid injections. An MRI was performed on 06/23/2014 which supported the above diagnoses and a back X-ray on 04/11/2013. Documentation was provided of electromyography (EMG) and nerve conduction velocity (NCV) tests completed on 04/01/2014. This injured worker completed a psychological evaluation. There is no surgical history related to this request. A progress note dated 08/08/2014 indicated patient complaints of low back pain with radiation of the pain in the left lower extremity. The injured worker also stated numbness and tingling sensations. This injured worker had a positive straight leg raise, weakness in the left EHL, tibialis anterior and gastrosoleus were 4/5 with decreased light touch in the posterior aspect of the calf. There is no documentation of medications used by this injured worker and on a report of 04/25/2014 the injured worker denied taking medications. The treatment plan for this injured worker is lumbar spinal surgery at L4-5 and L5-S1. A Request for Authorization form was included.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**purchase of bone stimulator for the lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODGACOEM Practice Guidelines

**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 - Lumbar and Thoracic, Bone growth stimulator

**Decision rationale:** The Official Disability Guidelines state either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion. However, there is no documentation of lumbar spinal surgery being approved. As the bone stimulator is used as an adjunct to surgery, and there is no documentation of a scheduled surgery, this request is not supported by the evidence based guidelines. As such, the request for purchase of bone stimulator for the lumbar spine is not medically necessary and appropriate.