

Case Number:	CM15-0119545		
Date Assigned:	06/30/2015	Date of Injury:	11/13/2013
Decision Date:	07/29/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/22/2015

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: Illinois, California, 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:

This injured worker is a 54-year-old male who sustained an industrial injury on 11/13/13. Injury occurred when he was struck by a fork lift door and pinned between the door and the forklift. Past medical history was negative for smoking, diabetes, renal disease or alcoholism. Conservative treatment included anti-inflammatory medications, muscle relaxants, physical therapy, epidural steroid injections, and activity modification. Records documented the 12/16/14 lumbar spine MRI showed a compression fracture at L2 and herniated nucleus pulposus at L5/S1 with degenerative spondylolisthesis. The 12/18/14 lumbar spine x-rays showed a compression fracture at L2 and disc collapse at L5/S1. The 6/4/15 treating physician report cited worsening low back and left lower extremity pain. Physical exam documented decreased left S1 sensation, difficulty with toe walk, positive straight leg raise, and absent left Achilles reflex. The treating physician noted segmental instability and disc collapse at L5/S1. There were no psychological issues and the injured worker had failed conservative treatment. Authorization was requested for an L5/S1 discectomy and fusion and associated post-surgical requests for 3-day inpatient stay, hot/cold therapy unit, muscle stimulator, bone growth stimulator, lumbosacral orthosis brace, and post-op physical therapy 2x6. The 6/9/15 utilization review certified the request for anterior lumbar discectomy and fusion at L5/S1, 3-day inpatient stay, hot/cold therapy unit, and 12 post-op physical therapy visits. The request for a post-operative muscle stimulator was non-certified based on absence of guideline support. The request for bone growth stimulator was non-certified

was the injured worker was a non-smoker with no confounding medical issues and was undergoing single level fusion. The request for lumbosacral orthotic brace as non-certified based on absence of guideline support.

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: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The California MTUS guidelines for transcutaneous electrotherapy relative to muscle stimulation do not recommend the use of NMES in the treatment of post-operative pain. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. Guideline criteria have not been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. Therefore, this 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.

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 & Thoracic Bone growth stimulators (BGS).

Decision rationale: The California MTUS guidelines are silent regarding bone growth stimulators. The Official Disability Guidelines indicate that bone growth stimulators are under study and may be considered medically necessary as an adjunct to lumbar 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; (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. Guideline criteria have not been met. The injured worker is undergoing an initial spinal fusion at one level with no indication of a grade III or worse spondylolisthesis in the submitted records. Past medical history is negative for smoking, diabetes, renal disease, or alcoholism, and osteoporosis is not documented. Therefore, this request is not medically necessary.

LSO Brace: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines 2nd Edition Chapter 12 Low Back Disorders (Revised 2007) page(s) 138-139.

Decision rationale: The California MTUS guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The revised ACOEM Low Back Disorder guidelines do not recommend the use of lumbar supports for prevention or treatment of lower back pain. However, guidelines state that lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post-operative treatment. The use of a lumbar support in the post-operative period for pain control is reasonable and supported by guidelines. Therefore, this request is medically necessary.