

Case Number:	CM15-0076799		
Date Assigned:	04/28/2015	Date of Injury:	02/22/2010
Decision Date:	05/28/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	04/22/2015

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: Florida

Certification(s)/Specialty: Family Practice

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 53 year old male patient who sustained an industrial injury on 02/20/2010. A primary treating office visit dated 11/19/2014 reported the patient with subjective complaint of without significant change since last visit, and is in need of medication refills. The following diagnoses are applied: cervical spondylosis without myelopathy; lumbar disc, and post-surgical status. The plan of care involved: refilling Norco, pending authorization to obtain a magnetic resonance imaging study, and follow up in 6 weeks. An orthopedic follow up dated 10/22/2014 reported current complaints of neck pain that radiates into bilateral upper extremities; greater on the left side. He is also with complaint of left shoulder, lumbosacral pain. He is diagnosed with cervical spondylosis with radiculopathy; rotator cuff tear, left shoulder post arthroscopic decompression and repair on 10/24/2012; and degenerative disc disease with associated facet arthropathy resulting in the lateral recess and foraminal stenosis. The impression noted: the patient is doing reasonable well in regards to the shoulder. He still has some mild residual pain but his range of motion and strength is better. At this time, no additional treatment recommended for the shoulder. Regarding the cervical pain, he wishes surgical intervention. He is to continue with current medications and follow up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bone Growth Stimulator Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG. Bone Growth Stimulator.

Decision rationale: Bone growth stimulators are not addressed by MTUS guidelines. Therefore, the ODG was referenced. The ODG states that there is conflicting evidence and that case-by-case recommendations are necessary regarding bone growth stimulators. Utilization review did not certify this request, stating that since the patient has not yet been approved for his procedure the requested postoperative bone growth stimulator does not satisfy guidelines for medical necessity. Independent medical review is in agreement with this determination. Likewise, this request is not considered medically necessary.