

Case Number:	CM13-0054339		
Date Assigned:	12/30/2013	Date of Injury:	10/20/2008
Decision Date:	11/05/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/19/2013

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 California. 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 56-year-old female with a reported injury on 10/20/2008. The mechanism of injury was not provided. The injured worker's diagnoses included radiculopathy, degeneration of the lumbar intervertebral discs, spondylolisthesis grade 1, and lumbar stenosis. The injured worker's previous treatments included medications and acupuncture. The injured worker's previous diagnostic testing included a lumbar spine MRI on 06/28/2013. Comparison was made to the study on 01/09/2009. The impression was discogenic disc disease at L3-4, L4-5, and L5-S1. At L3-4, in particular, there was a right paracentric disc protrusion, which has increased in size since the prior examination with a slight increase in the degree of compression of the right L4 nerve right and increase in canal stenosis. No pertinent surgical history was provided. The injured worker was evaluated on 09/11/2013 for complaints of increased prickly feeling in her right leg. She also complained of aching numbness in the right foot and pain in the bottom of the left foot. The clinician reported no interval changes on examination. There was tenderness to the left paraspinals of the lower lumbar and coccyx. Lateral bending 10 to 20 degrees with mild pain, extension 10 to 20 degrees with mild pain. On forward flexion, the patient was able to reach 25 degrees. Heel and toe walking were normal. Motor strength was normal in all groups bilaterally except the extensor hallucis longus and tibialis anterior muscles bilaterally, measured at 4/5. Straight leg raise test was positive on the left. The clinician's treatment plan was to request an EMG/NCV of the bilateral lower extremities and finalize a surgical plan. No medication list was provided. The requests were motorized cold therapy unit for 2 week rental and LSO brace. The rationale for the request was for postoperative care following a microdiscectomy. A Request for Authorization form was submitted on 10/07/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

MOTORIZED COLD THERAPY UNIT FOR TWO WEEK RENTAL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG KNEE & LEG, CONTINUOUS FLOW CRYOTHERAPY

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Continuous-flow cryotherapy.

Decision rationale: The request for Motorized Cold Therapy Unit for Two Week Rental is not medically necessary. The injured worker complained of prickly feelings and numbness in the right leg and foot. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery. Postoperative use generally may be up to 7 days including at home use. The request was placed simultaneously with the request for surgery, but there is no documentation supporting that the surgery had been approved. The request was for 2 week rental which exceeds the guideline recommendations. Additionally, the request did not include a body part for the unit to be used on or a frequency of use. Therefore, the request for Motorized Cold Therapy Unit for Two Week Rental is not medically necessary.

LSO BRACE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG LOW BACK, BACK BRACE POST OPERATIVE (FUSION)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

Decision rationale: The request for LSO brace is not medically necessary. The injured worker did not complain of back pain. The California MTUS/ACOEM Guidelines do not recommend lumbar supports for treatment of low back disorders as lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The request was submitted with the request for surgery, which the provided documentation does not indicate had been approved. Therefore, the request for LSO brace is not medically necessary.