

Case Number:	CM13-0069217		
Date Assigned:	01/03/2014	Date of Injury:	12/11/2005
Decision Date:	07/03/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/20/2013

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 Orthopaedic Surgery 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 45-year-old male with a date of injury of December 11, 2005. The mechanism of injury reported is low back pain experienced as the injured worker was picking up a recycle bin, which fell over after removing trash from it. A recent encounter note dated on November 26, 2013 notes moderate to severe low back pain with radiation to the left leg described as a burning pain. The pain is rated 8/10 on the Visual Analogue Scale (VAS). Symptoms are worse with sitting, lying down, and standing for more than thirty minutes. Left leg weakness is noted with symptoms of giving way. Episodic bowel and urinary incontinence is reported. Physical examination reveals palpable tenderness over the paraspinal musculature with restricted range of motion with pain at the end of the motion. Gait is restricted in the claimant cannot perform a heel and toe walk. Sensation is diminished to light touch and pinprick in the L4, L5, and S1 distribution. The current diagnosis is lumbar strain with radicular complaints, and multilevel disk desiccation, two-level disc herniation (L4-5, and L5-S1), and spinal stenosis syndrome (supported by MRI dated September 19, 2013). The record notes under treatment plan; a recommendation for cryotherapy, raised toilet seat, Walker, Lumbar Cyber Tech brace, and a Transcutaneous Electrical Nerve Stimulation (TENS) unit to be used postoperatively. There is no reference of procedure details in this progress note. Elsewhere in the medical record, a notation is made that the recommended procedure is a decompression hemilaminectomy, bilaterally, at L3, L4, and L5-S1 and was certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

CRYOTHERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (updated 12/04/13), Cold/Heat Packs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) online addition; Low Back Disorders: Clinical Measures-Hot and Cold Therapies, Cryotherapy.

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM) guidelines support the use of self-application of cryotherapy with reusable devices for use as a potential distracting or counter intent. The guidelines do not recommend other forms of cryotherapy, including chemicals or cryotherapy unit applications. Therefore, this request is recommended as not medically necessary.

TENS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS) Devices Page(s): 114-116.

Decision rationale: Treatment guidelines support the use of a Transcutaneous Electrical Nerve Stimulation (TENS) unit in certain acute postoperative settings for the first thirty days following surgery. In this setting, the purchase of a tens unit would not be supported. When noting that this request indicates only "TENS unit" it must be presumed that this is for the purchase of a TENS device. While there may be guideline support in select clinical settings for the use of this device in the postoperative period, there is no guideline support for the purchase of such a unit in this setting. As such, this request is recommended as not medically necessary.

LUMBAR CYBER TECH BRACE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (updated 10/09/13), Back Brace, postoperative (fusion).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Medical Treatment Guidelines, Low Back Complaints (online version).

Decision rationale: Treatment guidelines do not support the use of Lumbar Support Orthotics (LSO's) and other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or

postoperative treatment. An online review of the requested device indicates the requested brace is an LSO brace. The medical record provides documentation that the requested lumbar support brace is to be used in the postoperative setting. Documentation is also provided in the medical record of the proposed surgical treatment, noted to be a decompression hemilaminectomy of the lumbar spine at L3-4, L4-5, and L5-S1. When considering the proposed surgical intervention (which has been certified) and the clinical documentation indicating that this device is being requested for use in the postoperative setting, a clinical indication does exist for the use of a lumbar support brace. Therefore, this request is recommended as medically necessary.