

<b>Case Number:</b>	CM14-0001602		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	01/14/2012
<b>Decision Date:</b>	06/09/2014	<b>UR Denial Date:</b>	12/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2014

### 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 Orthopedic Surgery, has a subspecialty in Fellowship trained in Spine Surgery and is licensed to practice in California and Texas. 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 37 year old female who reported an injury on 01/17/2012 secondary to lifting a heavy object. An MRI of the lumbar spine on 07/28/2012 revealed disc herniation and annular tear at L5-S1 with bilateral neuroforaminal narrowing as well as diffuse disc protrusion at L3-4 with right neuroforaminal narrowing. She has been treated previously with an unknown duration of physical therapy and epidural steroid injections at L4-5 and L5-S1. The injured worker also began using a back brace around 05/31/2013 and reported that it helped to decrease pain. A repeat MRI of the lumbar spine on 10/01/2013 revealed posterior disc bulges at L3-4 and L4-5 without significant neural compression, and a posterior disc bulge at L5-S1 causing mild Final Determination Letter for IMR Case Number CM14-0001602 3 bilateral foraminal stenosis. The injured worker was evaluated on 12/18/2013 and reported pain of unknown severity in the lumbosacral region. On physical examination, she was noted to have decreased sensation in the right lateral foot and heel, absent right Achilles reflex, decreased right leg strength (4/5), and a positive straight leg raise on the right. It was documented that flexion and extension films revealed good motion at L5-S1 without any evidence of instability. She was recommended for an unspecified spinal surgery. A request for authorization was submitted for a lumbar brace and a cold therapy vascultherm unit. The documentation submitted for review failed to provide a request for authorization form.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LUMBAR BRACE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): (s) 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Lumbar supports.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): (s) 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Lumbar supports.

**Decision rationale:** California MTUS/ACOEM Guidelines do not support the use of a lumbar support for treatment of low back pain beyond the acute phase of symptom relief. The injured worker has been treated for low back pain since 01/17/2012. She is no longer in the initial or acute phase of treatment, but rather the chronic phase. Official Disability Guidelines recommend lumbar supports as an option for compression fractures and specific treatment of spondylolisthesis, documented instability. However, these guidelines state that there is very limited, low-quality evidence to warrant a lumbar support for the treatment of nonspecific low back pain. The injured worker reported lumbosacral pain and clinical findings in the most recent evaluation were highly consistent with radiculopathy. A recent MRI revealed a posterior disc bulge at L5-S1 causing mild bilateral foraminal stenosis. It was documented that flexion and extension films revealed good motion at L5-S1 without any evidence of instability. There is a lack of documented evidence to indicate that the injured worker suffers from a compression fracture, spondylolisthesis, or instability. Furthermore, it was noted that the injured worker has used a back brace since 05/31/2013 and reported that it helped to decrease pain. The documentation submitted for review fails to provide a rationale to warrant the purchase of an additional back brace. As such, the request for a Lumbar Brace is not medically necessary.

**COLD THERAPY VASCUTHERM UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): (s) 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Lumbar supports.

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

**Decision rationale:** Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery for up to 7 days, but not for nonsurgical treatment. A rationale for the request for a cryotherapy unit was not included in the medical records submitted for review. The most recent evaluation documents that a request for authorization for a surgical procedure was submitted, but there is no documentation of an approval for such request. There is a lack of documented evidence to indicate that the injured worker would benefit from cryotherapy at this time. Furthermore, the guidelines do not support the purchase of a cryotherapy unit, but rather a rental for 7 days. As such, the request for a Cold Therapy Vascutherm Unit is not medically necessary.

