

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0002341 |                              |            |
| <b>Date Assigned:</b> | 01/24/2014   | <b>Date of Injury:</b>       | 11/23/2011 |
| <b>Decision Date:</b> | 06/24/2014   | <b>UR Denial Date:</b>       | 12/31/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/07/2014 |

### 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 Psychiatry 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 patient is a 29-year-old female who has filed a claim for lumbar spinal stenosis associated with an industrial injury date of November 23, 2011. Review of progress notes reports low back pain radiating to the right hip and into the right leg. Patient also complains of daily migraines. Findings include restricted and painful lumbar range of motion, decreased light touch sensation of bilateral plantar feet, and guarded gait. Patient is moderately obese. A lumbar MRI dated September 11, 2013 showed a 7-mm right paracentral disk protrusion encroaching upon the thecal sac and neural foramina, and mild hypertrophic facet arthropathy at L4 to 5. Treatment to date has included injections, rhizotomy, physical therapy, opioids, Soma, Fioricet, and diphenhydramine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME: CYBERTEETH BACK BRACE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** As stated on page 301 of the MTUS ACOEM Low Back Complaints Guidelines, back braces have not been shown to have any lasting benefit beyond the acute phase of symptom relief. According to ODG, they are indicated for management of compression fractures, spondylolisthesis, or documented instability. There is very low quality evidence for treatment of nonspecific Low Back Pain as a conservative option. Lumbar supports are not recommended for prevention. In this case, the patient does not have fractures, spondylolisthesis, or documented instability of the lumbar spine to support the use of a back brace. Therefore, the request for Cyberteeth Back Brace was not medically necessary.

**DME: DJO BONE GROWTH STIMULATOR:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 chapter, Bone growth stimulators (BGS)

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, bone growth stimulation may be medically necessary as an adjunct to spinal fusion surgery in patients with risk factors for failed fusion including multilevel fusion, previous failed fusion, grade III or worse spondylolisthesis, current smoking habit, diabetes, renal disease, alcoholism, or significant osteoporosis. In this case, the requesting physician indicated the need for lumbar laminectomy at L4-S1, and fusion at L4-5 and L5-S1. However, there is no documentation that this surgery has been authorized or is scheduled to proceed. Therefore, the request for DJO bone growth stimulator was not medically necessary per the guideline recommendations of ODG.

**DME: COLD COMPRESSION THERAPY UNIT FOR POST OPERATIVE USE FOR THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 chapter, Cold/heat packs; Knee & Leg chapter, Continuous-flow cryotherapy

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. ODG low back chapter states that cold/hot packs are recommended as an option for acute pain. There is minimal evidence supporting the use of cold therapy. ODG knee and leg chapter states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. There is no discussion regarding cold compression therapy unit

for the lumbar spine. In this case, the requesting physician indicated the need for lumbar laminectomy at L4-S1, and fusion at L4-5 and L5-S1. However, there is no documentation that this surgery has been authorized or is scheduled to proceed. Therefore, the request for cold compression therapy unit for post operative use for the lumbar spine was not medically necessary per the guideline recommendations of ODG.