

<b>Case Number:</b>	CM14-0012275		
<b>Date Assigned:</b>	01/31/2014	<b>Date of Injury:</b>	12/03/2011
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	01/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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 Neurological 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 31 year-old female who was reportedly injured on 12/3/2011. The mechanism of injury is noted as a lifting injury. The most recent progress note, dated 1/2/2014 indicates that there are ongoing complaints of low back pain that radiates into the left lower extremity. The physical examination demonstrated lumbar spine: antalgic gait, positive tenderness to palpation over the L5-S-1 area with palpable paraspinal muscle spasms, limited range of motion. Muscle strength 3/5 left Gastrosoleus. Injured worker has decreased sensation in the left leg in the L5-S-1 distribution. Straight leg raise is positive on the left. Extension at 20 causes pain radiating into the left foot laterally. There is mention of an magnetic resonance image of the lumbar spine dated 9/3/13 which states evidence of disc protrusion at L5 S1, significant disc desiccation as same level. Previous treatment includes medications, and conservative treatment. A request was made for cold therapy, bone growth stimulator, 5-7 inpatient hospital stay and was not certified in the pre-authorization process on 1/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold Therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 3rd Ed., Low Back Disorders (update to Chapter 12).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Continuous Flow Cryotherapy - (updated 7/29/14).

**Decision rationale:** According to Official Disability Guidelines cold therapy is recommended as an option after surgery, but not for nonsurgical treatment. After review the medical records provided the requested surgical procedure has not been approved at this point in time. Therefore this request is deemed not medically necessary.

**Bone Growth Stimulator:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Bone Growth Stimulators (BGS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 03/31/14).

**Decision rationale:** After review the medical records provided the requested surgical procedure has not been approved at this point in time. Therefore this request for a bone growth stimulator is deemed not medically necessary.

**Inpatient Hospital 5-7 Days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Hospital Length of Stay (LOS).

**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 - Lumbar & Thoracic (Acute & Chronic). Hospital Length of Stay. Updated 8/22/2014.

**Decision rationale:** After review the medical records provided the requested surgical procedure has not been approved at this point in time. Therefore this request for Hospital length of stay is deemed not medically necessary.