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| <b>Case Number:</b>   | CM14-0012693 |                              |            |
| <b>Date Assigned:</b> | 02/21/2014   | <b>Date of Injury:</b>       | 04/27/2010 |
| <b>Decision Date:</b> | 06/26/2014   | <b>UR Denial Date:</b>       | 01/24/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/31/2014 |

### 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 Occupational Medicine 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:

Patient is a 60 year-old female with date of injury 04/27/2010. The patient underwent a 360° fusion at L4-5 and L5-S1 on 11/21/2013. The medical record associated with the request for authorization, a primary treating physician's progress report, dated 01/07/2014, lists subjective complaints as constant postoperative back pain, rated 7-8/10, with radiation to the bilateral lower extremities, worse in the right leg and at the bottom of the foot. Objective findings: Physical examination revealed incision was clean, dry and intact. Negative Straight leg test. Motor examination was grossly intact in lower extremities. Light touch was intact. Diagnosis: 1. Status post anterior/posterior lumbar fusion at L4-5 and L5-S1 on 11/21/2013, with residual low back pain and lower extremity pain 2. Grade 1 anterolisthesis at L4-L5 with instability on flexion-extension x-rays 3. Severe disc height collapse and neural foraminal stenosis at L5-S1 with bilateral lower extremity radiculopathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 [REDACTED] COLD THERAPY RECOVERY SYSTEM WITH WRAP FOR UP TO 21 DAYS([REDACTED]): 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 - Lumbar & Thoracic (Acute & Chronic), Cold/heat packs

**Decision rationale:** The [REDACTED] cold therapy recovery system is a continuous-flow cryotherapy unit. According to the Official Disability Guidelines, there is minimal evidence supporting the use of cold therapy except in the acute phase of an injury or for the first seven days postoperatively. The request exceeds the guidelines and thus is not medically necessary.

**1 [REDACTED] UNIT WITH SUPPLIES FOR 3 MONTHS ([REDACTED] [REDACTED]):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines §§9792.20 - 9792.26 Page(s): 118-120.

**Decision rationale:** The [REDACTED] unit is a combination TENS unit and interferential current stimulator. According to the MTUS an interferential current stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The request is not medically necessary.

**1 [REDACTED] LSO (LUMBAR SACRAL ORTHOSIS) BACK BRACE ([REDACTED] [REDACTED]):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL ENVIRONMENTAL MEDICINE, CHAPTER 12 LOW BACK COMPLAINTS, 298,301

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** According to the MTUS, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The request is not medically necessary or appropriate.

**1 FRONT WHEEL WALKER( THROUGH [REDACTED]):** Overturned

**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) Knee & Leg (Acute & Chronic), Walking aids (canes, crutches, braces, orthoses, & walkers)

**Decision rationale:** A walker had been authorized as necessary postoperative DME at the same time the surgery was authorized. It is unclear why an additional authorization is needed for a walker at this time. However, at the time of the request, the patient was still in the 90 day postoperative period and complaining of severe postoperative pain radiating to both lower extremities. Although there is no mention of the patient's gait in the examination at the time of the postoperative visit, subjective complaints of postoperative pain of this nature would indicate that the patient is still having problems ambulating. A front wheel walker is medically necessary.