

Case Number:	CM14-0022840		
Date Assigned:	06/11/2014	Date of Injury:	08/02/2013
Decision Date:	08/05/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/24/2014

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 23-year-old male employee with date of injury of 8/5/2013. A review of the medical records indicates that the patient is undergoing treatment for displacement of lumbar intervertebral disc without myelopathy; lower back pain with left lower extremity radiculopathy; degeneration of lumbar or lumbosacral intervertebral disc; rule out lumbar facet joint syndrome/hypertrophy and lumbar spondylosis. Subjective complaints include severe lower back pain at 8/10. He complains of low back pain travelling to bilateral legs posteriorly to knee, left more than right, which he describes as aching and cramping. He experiences numbness and tingling in left leg. He experiences occasional weakness in left leg and back. Pain medication reduces pain to a 4/10. Patient states he has difficulty sitting for long periods of time and driving a car. He states that the pain is aggravated by repetitive stooping, kneeling, squatting, bending, neck bending, overhead reaching, twisting, lifting, carrying, pulling, pushing, climbing, and lifting heavy objects and cold weather. He states he has difficulty dressing, putting socks and shoes on and preparing food. He states he sleeps 5 hours a night without medication, 8 hours with medication and suffers from headaches, anxiety and symptoms of depression. Objective findings include L5-S1, a 2-3mm posterior disc bulge; reflexes for hamstrings, knees and ankles are normal bilaterally; right straight leg raise with no pain; left straight leg raise at 40 degrees with referred pain to lower back and posterior thigh. Palpation reveals paraspinal tenderness and muscle guarding on the right. Palpation reveals spinal tenderness and muscle guarding. Palpation reveals tenderness at S1 on the right. Positive Kemp's bilaterally. Treatment has included hydrocodone 2.5/325 mg 2-3 times daily, omeprazole for gastritis 20mg, cyclobenzaprine (muscle spasms), Naproxen, lumbar support, physiotherapy and physical therapy (p. 6-7). The utilization review dated 1/17/2014 non-certified the use of a cold therapy unit and back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR SACRAL ORTHOSIS BRACE: Upheld

Claims Administrator 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 (Acute & Chronic), Procedure Summary, Lumbar Support.

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 (Lumbar and Thoracic), Lumbar Support.

Decision rationale: ACOEM states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief". The Official Disability Guidelines (ODG) states, lumbar braces are not recommended for prevention. Recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent low back pain (LBP). (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (van Duijvenbode, 2008). The ODG states for use as a treatment are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP. The patient is beyond the acute phase of treatment and the treating physician has provided no documentation of spondylolisthesis or documented instability. As such, the request for lumbar sacral orthosis brace is not medically necessary.

COLD THERAPY UNIT: 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 (Acute & Chronic), Procedure Summary, Cold/Heat Packs.

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 and Thoracic), Lumbar Support <http://www.deroyal.com/medicalproducts/orthopedics/product.aspx?id=pc-temptherapy-coldtherunit>.

Decision rationale: MTUS is silent on the use of cold therapy units. Official Disability Guidelines (ODG) for heat/cold packs states Recommended as an option for acute pain. At-home

local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007). The uses of devices that continually circulate a cooled solution via a refrigeration machine have not been shown to provide a significant benefit over ice packs. As such, the request for cold therapy unit is not medically necessary.