

<b>Case Number:</b>	CM14-0031789		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	03/15/2005
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2014

### 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 and is licensed to practice in 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 58 year old male who sustained an injury on 03/15/05. No specific mechanism of injury was noted. Prior treatment included previous lumbar laminectomy in 2012 followed by further microdiscectomy. Other treatment included epidural steroid injections. The injured worker was also followed for physical therapy. The injured worker reported minimal benefits from the use of physical therapy. Radiographs of the lumbar spine noted laminectomy defects at L4 with apparent pars fractures at L4. MRI of the lumbar spine from 01/29/14 noted no evidence of canal stenosis either at L3-4 or L4-5. There was a small amount of retrolisthesis 2-3 millimeter both at L3-4 and L4-5 with disc osteophyte complexes contributing to mild/moderate neural foraminal stenosis at L3-4. There was osteophytic spurring at L4-5 with facet hypertrophy contributing to bilateral neural foraminal stenosis which increased in comparison with prior studies. Marked degenerative endplate changes were evident at L4-5. There was subluxation of the facet joints along with disruption of the pars at L4-5. Mild dorsal kyphotic curve in the lower thoracic spine and upper lumbar spine was noted. Computed tomography (CT) of the lumbar spine on 01/29/14 also noted disruption of the pars interarticularis at L4. Slight retrolisthesis at L3-4 was evident. Degenerative endplate changes at L4-5 were also noted. The injured worker was seen by treating physician on 05/02/14. Per the report the injured worker continued to have complaints of low back pain radiating to the right lower extremity with ambulation. Numbness in the big toe of the right foot was reported. Physical examination noted intact strength in the lower extremities with decreased sensation at the right foot. The injured worker had 5 millimeters of translation between flexion/extension at L4-5. No independent radiology reports were available for review documenting evidence of instability. The requested post-operative Lumbar-Sacral Orthosis (LSO) brace, Motorized cold

unit, and home health nursing for dressing changes were denied by utilization review on 02/24/14.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**LSO brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Chapter.

**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, Back Brace, Post-operative.

**Decision rationale:** The request for a post-operative lumbar LSO brace is not medically necessary. The surgical request for this injured worker was not felt to be medically appropriate. Therefore this request for a post-operative lumbar brace would not have been supported as medically necessary.

**Motorized 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, Low Back Chapter & Neck & Upper Back Chapter, Continuous-flow cryotherapy.

**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, Hot/Cold Packs.

**Decision rationale:** The request for a motorized cold therapy unit is not medically necessary. The surgical request for this injured worker was not felt to be medically appropriate. Therefore this request for a post-operative motorized hot/cold unit would not have been supported as medically necessary.

**Home health nursing for daily dressing changes for (2) weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services.

**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, Home Health Care.

**Decision rationale:** The request for a home health care for dressing changes for 2 weeks is not medically necessary. The surgical request for this injured worker was not felt to be medically

appropriate. Therefore this request for a post-operative home health care would not have been supported as medically necessary.