

Case Number:	CM14-0049560		
Date Assigned:	07/07/2014	Date of Injury:	08/08/2001
Decision Date:	08/26/2014	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	04/17/2014

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:

The claimant injured his low back on 08/08/01 and a lumbar brace is under review. He has a history of chronic low back pain with impaired range of motion and limitations in activities of daily living. A MRI of the lumbar spine dated 05/28/13 revealed very severe L4-5 central stenosis tethering the nerve roots due primarily to facet disease. There was severe bilateral L4-5 and L5-S1 foraminal stenosis with facet spurs contacting the bilateral nerve roots at these levels. He had electrodiagnostic studies on 05/29/13 that showed evidence of right L4-5 radiculopathy. He underwent lumbar surgery for bilateral L2-S1 laminectomy and foraminotomy on 03/25/14; postoperatively he developed complications of the wound. He had a suspected compromise of the surgical skin flap graft. He was treated with hyperbaric oxygen. On 04/10/14, he saw [REDACTED] for his first post-op visit. He completed 8 hyperbaric oxygen treatments. He still had pain but the pain did improve. The sutures were intact and he had intact motor strength and sensation. There was good alignment of the vertebral bodies on x-rays. The diagnoses included low back pain, right lumbar radiculopathy, lumbar stenosis and degenerative disc disease. He was to continue his antibiotics, pain medications and the hyperbaric treatment. On 04/17/14, he still had low back pain but no lower extremity pain, numbness, tingling, or weakness. He was still receiving wound therapy; physical therapy was under consideration in the near future. On 05/15/14, he saw [REDACTED] again. His right lower extremity was significantly improved. He was doing well. Physical therapy was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar brace: 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 - Lumbar and Thoracic (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X Official Disability Guidelines (ODG), Low Back, Lumbar support.

Decision rationale: The history and documentation do not objectively support the request for a lumbar brace which appears to have been recommended postoperatively. The Official Disability Guidelines do not recommend for prevention but rather 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 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) Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). Under study for post-operative use; see back brace, post-operative (fusion). Among home care workers with previous low back pain, adding patient-directed use of lumbar supports to a short course on healthy working methods may reduce the number of days when low back pain occurs, but not overall work absenteeism. (Roelofs, 2007) Acute osteoporotic vertebral compression fracture management includes bracing, analgesics, and functional restoration. (Kim, 2006) An RCT to evaluate the effects of an elastic lumbar belt on functional capacity and pain intensity in low back pain treatment found an improvement in physical restoration compared to control and decreased pharmacologic consumption. (Calmels, 2009) This RCT concluded that lumbar supports to treat workers with recurrent low back pain seems to be cost-effective, with on average 54 fewer days per year with LBP and 5 fewer days per year sick leave. (Roelofs, 2010) This systematic review concluded that lumbar supports may or may not be more effective than other interventions for the treatment of low-back pain. (Van Duijvenbode, 2008) For treatment of nonspecific LBP, compared with no lumbar support, an elastic lumbar belt may be more effective than no belt at improving pain (measured by visual analogue scale) and at improving functional capacity (measured by EIFEL score) at 30 and 90 days in people with sub-acute low back pain lasting 1 to 3 months. However, evidence was weak (very low-quality evidence). (McIntosh, 2011) In this case, it appears that the lumbar brace was recommended for postop use but lumbar supports are under study for this indication. There is no evidence of a compression fracture or instability of the spine to support this type of request. Other than soft tissue compromise and problems with a skin graft, there were no postoperative complications that may have resulted in spinal instability. The request for lumbar brace has not been clearly demonstrated and is therefore not medically necessary.

