

<b>Case Number:</b>	CM15-0002844		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	08/06/2013
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	12/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 41-year-old male who reported an injury on 08/06/2013. The mechanism of injury was not specifically stated. The current diagnoses include chronic intractable low back pain, radiculitis in the left lower extremity, annular fissure with disc protrusion at L5-S1, and thoracic strain. The injured worker presented on 10/21/2014 for a followup evaluation with complaints of 9/10 moderate to severe low back pain. Upon examination, there was an antalgic gait, tenderness in the paralumbar musculature, tenderness in the parathoracic musculature, tenderness in the posterior superior iliac spine region, positive muscle spasms, 5/5 motor strength, 2+ deep tendon reflexes, 10 degree forward flexion, 10 degree lateral tilt, 10 degree rotation, positive straight leg raise, and an inability to flex or extend the left lower extremity without severe pain. Recommendations included a lumbar decompression and fusion. The injured worker was also issued prescriptions for diclofenac XR 100 mg and omeprazole 20 mg. There was no Request for Authorization Form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME Back 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 (ODG) Low Back Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back Chapter, Back brace, post operative (fusion).

**Decision rationale:** The Official Disability Guidelines state a postoperative back brace is currently under study, and given the lack of evidence supporting the use of these devices, a standard brace is preferred over a custom postoperative brace following a fusion. The injured worker is not scheduled to undergo a lumbar fusion. Therefore, the medical necessity for the requested durable medical equipment has not been established in this case. As such, the request is not medically appropriate.

**Physical therapy, three times a week for six weeks for the low back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10.

**Decision rationale:** The California MTUS Guidelines state the initial course of therapy means 1 half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. The injured worker has been issued authorization for a laminotomy and a microdiscectomy at L5-S1. The California MTUS Guidelines recommend postsurgical physical medicine treatment at a rate of 16 sessions over 8 weeks following a discectomy/laminectomy. The current request for 18 initial sessions of postoperative physical therapy would exceed guideline recommendations. Therefore, the request is not medically appropriate at this time.

**Inpatient Stay 2-3 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) Hospital Length of Stay (LOS)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back Chapter, Hospital Length of Stay (LOS).

**Decision rationale:** The Official Disability Guidelines recommend a median length of stay of 1 day following a discectomy. The current request for a 2 to 3 day inpatient stay exceeds guideline recommendations. As such, the request is not medically appropriate.