

<b>Case Number:</b>	CM15-0204669		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	07/30/2015
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	10/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 55 year old male, who sustained an industrial injury on 7-30-15. The injured worker was diagnosed as having lumbar sprain, left lower extremity radiculopathy and grade I anterolisthesis at L4-L5 with dynamic instability. Subjective findings (9-11-15) indicated intermittent pain in the lower back that radiates to the left lower extremity. The injured worker rated his pain 4 out of 10 most days and 6-7 out of 10 on a bad day. The injured worker is currently working with no restrictions. He is not taking any medications currently. Objective findings (9-11-15) revealed a positive straight leg raise test on the left, slight tenderness to palpation of the lumbar paravertebral musculature and intact sensation in the lower extremities. Treatment to date has included lumbar x-rays on 9-11-15 showing grade I anterolisthesis at L4-L5 and bilateral facet hypertrophy at L5-S1 and a home exercise program. The Utilization Review dated 10-9-15, non-certified the request for a Kronos lumbar pneumatic brace (purchase) and a Solar Care FIR heating system (purchase).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) Kronos Lumbar Pneumatic Brace (Purchase): 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), Lumbar Supports.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care.

**Decision rationale:** The ACOEM chapter on low back complaints and treatment recommendations states: Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This patient has chronic ongoing low back complaints. Per the ACOEM, lumbar supports have no lasting benefit outside of the acute phase of injury. This patient is well past the acute phase of injury and there is no documentation of acute flare up of chronic low back pain. Therefore criteria for use of lumbar support per the ACOEM have not been met and the request is not medically necessary.

**One (1) Solar Care Fir Heating System (Purchase): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic): Heat therapy; Infrared therapy (IR).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care.

**Decision rationale:** The ACOEM chapter on low back complaints does indicate that the application of heat is a recommended treatment option. The patient does have symptomatic low back pain complaints. The documentation does not however establish the need for a specialized heating system versus traditional at home application of heated compresses. Therefore the request is not medically necessary.