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| <b>Case Number:</b>   | CM15-0027030 |                              |            |
| <b>Date Assigned:</b> | 02/19/2015   | <b>Date of Injury:</b>       | 04/15/2013 |
| <b>Decision Date:</b> | 04/07/2015   | <b>UR Denial Date:</b>       | 01/29/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/12/2015 |

### 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  
 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:

This 57-year-old female reported a work-related injury on 04/15/2013. According to the consultation notes dated 1/15/15, the injured worker had undergone L4-5 laminectomy and fusion for spinal stenosis at L4-5. She had reported lower back pain that radiated down to her left lower extremity. Previous treatments include medications, epidural steroid injections and physical therapy. The treating provider requests a cold therapy unit and an LSO Chair back brace purchase. The Utilization Review on 01/29/2015 non-certified the request for a cold therapy unit and a back brace, citing ODG and CA MTUS guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter under continuous flow cryotherapy.

**Decision rationale:** The patient was injured on 04/15/13 and presents with low back pain that radiates down to her left lower extremity. The request is for a COLD THERAPY UNIT. The utilization review denial rationale is that there is no documentation that standard applications of low tech hot and cold to relieve acute local pain would be ineffective. There is no RFA provided and the patient is to remain off of work until 02/14/15. The report with the request is not provided and there is no discussion regarding the request. The MTUS and ACOEM Guidelines do not discuss water therapy units. ODG Guidelines Pain Chapter under continuous flow cryotherapy states: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In a postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated. The treater does not provide a reason for the request. On 01/15/15, the patient underwent a L4-5 laminectomy with bilateral medial facetectomy and foraminotomies as well as a L4-5 transforaminal lumbar interbody fusion. In this case, ODG Guidelines do not support this type of device other than for postoperative recovery, which the patient had. The requested cold therapy unit IS medically necessary.

**LSO Chair Back Brace, purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines; Low back; Back Brace.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official disability guidelines low back chapter, lumbar supports.

**Decision rationale:** The patient was injured on 04/15/13 and presents with low back pain that radiates down to her left lower extremity. The request is for a LSO CHAIR BACK BRACE PURCHASE. There is no RFA provided and the patient is to remain off of work until 02/14/15. The report with the request is not provided and there is no discussion regarding the request. ACOEM Guidelines page 301 on lumbar bracing states: Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of the symptom relief. ODG Guidelines under its low back chapter, lumbar supports states: prevention: not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. Under treatment, ODG further states: recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and treatment for nonspecific LBP (very low quality evidence, but may be a conservative option). There was no reason provided for the request. In this case, the patient is diagnosed with cervical spine strain with right sided radiculopathy, cervical sprain/strain with left sided radiculopathy, thoracic spine sprain/strain, lumbar spine sprain/strain with left radiculopathy, right shoulder sprain/strain, and left shoulder sprain/strain. The patient does not present with fracture, spondylolisthesis, or documented instability to warrant lumbar bracing. For nonspecific low back pain, there is very low quality evidence. The requested LSO chair back brace IS NOT medically necessary.

