

<b>Case Number:</b>	CM15-0038450		
<b>Date Assigned:</b>	03/09/2015	<b>Date of Injury:</b>	01/14/2009
<b>Decision Date:</b>	04/16/2015	<b>UR Denial Date:</b>	02/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/02/2015

### 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, Hawaii  
 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 42-year-old male, who sustained an industrial injury on January 14, 2009. He has reported lower back pain and leg pain. The injured worker was diagnosed as having lumbar intervertebral disc displacement and lumbar spine stenosis. Treatment to date has included medications and imaging studies. Currently, the injured worker complains of continued lower back pain and leg pain. Physical examination showed left leg weakness and decreased range of motion and a broad-based gait. The treating physician requested a cold therapy unit for a thirty-day trial and a lumbar back brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cold therapy unit 30-day rental:** 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) Knee & Leg (updated 01/30/15) continuous-flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder continuous flow cryotherapy.

**Decision rationale:** The patient presents with pain affecting the lumbar spine. The current request is for Cold Therapy Unit 30 day rental. The treating physician states, "At this time, the patient wishes to pursue surgical intervention secondary to both sensory, motor, and reflex findings; therefore I will request surgical authorization for the following: L5-S1 laminectomy/dissectomy." (32B) The ODG guidelines state, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." In this case, the treating physician has requested authorization for a surgery but it is not clear in the records provided for review if the patient is in the post surgical timeframe. In addition, the ODG guidelines only recommend the use of a cold therapy unit for 7 days and the prescribed 30 days is beyond the ODG recommendation. The current request is not medically necessary and the recommendation is for denial.

**Lumbar 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 (updated 01/30/15) Back brace, post operative (fusion).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Lumbar Supports.

**Decision rationale:** The patient presents with pain affecting the lumbar spine. The current request is for Lumbar back brace. The treating physician states, "He has been having flare-ups every 3-4 months. The patient is unable to pursue physical therapy because of the severity of his pain and symptoms." (30B) The report with this request was not provided for review. The ODG guidelines state, "Not recommended for prevention. 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." In this case, it is not clear if this brace is being recommended for the postsurgical timeframe and there is not any documentation that the brace is being used for treatment of spondylolisthesis or documented instability. The current request is not medically necessary and the recommendation is for denial.